DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01312 (03/2017)

STATE OF WISCONSIN

IRIS PROVIDER APPLICATION

INSTRUCTIONS: Completion of this form is not required through Wisconsin State Statute; however, completion of this form is an IRIS program requirement. Applicants will not be considered as IRIS program service providers until all necessary paperwork is completed, submitted, and verified.

Personally identifiable information on this form is collected to verify that the application is complete and accurate, and will be used only for this purpose.

PROVIDER DEMOGRAPHICS

Organization Name

Provider's Name (Last, First, MI)	Telephone Number	Email Address ☐ *May be published in Provider Directory*

Title

Are you applying as (choose one): ☐ Agency ☐ Individual Practitioner

Type of Application: ☐ Initial Application ☐ Reinstatement

W-9 Name (as shown on income tax return)	W-9 Business Name (if different from W-9 name)
W-9 Exempt: ☐ Yes ☐ No	State of Wisconsin Department of Financial Institutions ID Number:

BILLING AND CLAIMS CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*
Fax Number		Internet Address ☐ *May be published in Provider Directory*

Address	City	State	Zip Code	County

RENDERING PROVIDER CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*
Fax Number		Internet Address ☐ *May be published in Provider Directory*

Address	City	State	Zip Code	County

DAILY OPERATIONS CONTACT INFORMATION

Check all that apply: ☐ Primary Office ☐ Mailing Address ☐ Billing Address

National Provider Identifier (if applicable):	Wisconsin Provider Management Identifier (if applicable):
Tax Identification Number:	Tax Qualifier: ☐ EIN ☐ SSN

Organization Name

Name – Contact Person	Telephone Number	Email Address ☐ *May be published in Provider Directory*

Fax Number		Internet Address ☐ *May be published in Provider Directory*		
Address	City	State	Zip Code	County

SERVICES TO BE PROVIDED: List the service(s) you wish to provide. Please reference the IRIS Service Definition Manual for a complete list of allowable services.

Services	**Does this service require a license or certification?**

LICENSING / CERTIFICATION: List all current licenses and certificates (if applicable). A copy of each is required with this application.

Title of Licensure/Certification	Type of Licensure/Certification	Licensure/Certification Number	State in which Licensure/Certification Obtained	Expiration Date

By signing below, I certify that background checks on all employees have been completed in accordance with the Wisconsin Caregiver Program.

If I am to provide specialized transportation, I certify that the vehicle used is and will be mechanically sound, has properly functioning lighting, safety, ventilation, and braking systems, and properly inflated tires without excessive wear. I further certify that proper licensing and insurance has been verified and is attached.

I understand and agree that this application will not be processed until it is deemed complete by DHS. It is my responsibility to provide a complete application. I understand and agree that the burden of producing adequate information in a timely manner and for resolving doubts is my responsibility.

I certify that the information in this document and all attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after provider approval has been awarded, may lead to suspension or termination of provider approval.

SIGNATURE – Provider	Date Signed

Please submit this application to your Fiscal Employer Agent (FEA) using ONE of the following methods:

AGENCY	FAX	EMAIL	GROUND MAIL
GT Independence	888-972-3891	customerservice@gtindependence.com	215 Broadus St. Sturgis, MI 49091
iLIFE	414-918-4463	IRIS.Vendor@iLIFEfms.com	6100 North Baker Road Glendale, WI 53209
Outreach Health Services	877-901-5826	wivendor@outreachfiscalagent.com	204 3rd Avenue, Suite 110 P.O. Box 945 Osceola, WI 54020
Premier Financial Management Services	888-302-3607	vendorpaperwork@premier-fms.com	10425 W North Ave, Suite 345 Milwaukee, WI 53226

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