Security Health Plan[SM]

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711 or 715-221-9898
Fax 715-221-9500

Provider/Practice Affiliation Request

To be completed by requesting practice

Nonaffiliated non-physician practices interested in affiliation with Security Health Plan must complete this form for consideration. ***Note: The practice must be established prior to the request for affiliation.***

Practice name ______________________ Months/Years in business ___________

Practice specialty ______________________

Contact name ______________________ Title ______________________

Phone (______) ______________ Email ______________________

Unique services your practice provides ______________________

Are you already an affiliated practice requesting affiliation of an additional site? ☐ Yes ☐ No

Does your practice accept Medicare assignment? ☐ Yes ☐ No

Which of the following products are you requesting affiliation with?

☐ Medicare Advantage ☐ BadgerCare Plus ☐ Commercial *(large and small employer, individual and family, Medicare Select)*

Independent N.P. practices must submit a collaborative agreement with a Security Health Plan affiliated physician of the same specialty.

Individual provider information *(if your request for affiliation is approved, a credentialing application will be sent electronically to the email address provided)*

Provider name and credentials e.g. PT, MSW	Date of birth	NPI	Email address

List top 10 CPT codes and billed charge for each CPT code

Code	Charge	Code	Charge

Address

Main location (include county)

____

Additional location requesting affiliation (include county)

____

Please attach information which demonstrates why your practice should be considered for affiliation.

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