

Screen Shots of ForwardHealth Portal

Provider Type ?

Required fields are indicated with an asterisk (*).

Provider Type*

<input type="radio"/> Anesthetist	<input type="radio"/> Nurse in Independent Practice
<input type="radio"/> Audiologist	<input type="radio"/> Occupational Therapist
<input checked="" type="radio"/> Behavioral Treatment	<input type="radio"/> Optician
<input type="radio"/> Chiropractor	<input type="radio"/> Optometrist
<input type="radio"/> Dental Provider	<input type="radio"/> Physical Therapist
<input type="radio"/> Hearing Instrument Specialist	<input type="radio"/> Physician
<input type="radio"/> Home Health/Personal Care Worker	<input type="radio"/> Physician Assistant
<input type="radio"/> Individual Medical Supply Provider	<input type="radio"/> Podiatrist
<input type="radio"/> Medical Equipment Vendor	<input type="radio"/> Prenatal Care Coordination Worker (PNCC)
<input type="radio"/> Mental Health/Substance Abuse-Individual	<input type="radio"/> Speech-Language Pathologist
<input type="radio"/> Nurse Practitioner	

View [Enrollment Criteria](#).

Provider Specialty ?

Required fields are indicated with an asterisk (*).

Provider Specialties *

<input type="radio"/> Behavioral Treatment Licensed Supervisor
<input checked="" type="radio"/> Behavioral Treatment Technician
<input type="radio"/> Behavioral Treatment Therapist
<input type="radio"/> Focused Treatment Licensed Supervisor
<input type="radio"/> Focused Treatment Therapist

View [Enrollment Criteria](#).

FYI, the Enrollment Criteria link just takes you back to the Provider Enrollment Information page.

Screen Shots of ForwardHealth Portal

Additional Information ?

Required fields are indicated with an asterisk (*).

License Number

State Of License

FYI, you can just select "Next" to move on without adding info. (Paraprofessionals)

Screen Shots of ForwardHealth Portal

Medicare/Medicaid Information ?

Required fields are indicated with an asterisk (*).

Are you Medicare Part B Enrolled?*

- Enrolled
- In the process of enrolling
- Not enrolled or in the process of enrolling

Effective Date

Is the provider enrolled in Medicaid or CHIP in a state other than Wisconsin?*

- Enrolled
- In the process of enrolling
- Not enrolled or in the process of enrolling

State(s) and Effective Date(s)

Previous

Next

Save & Exit

Screen Shots of ForwardHealth Portal

Wisconsin Medicaid Declaration of Supervision for Nonbilling Providers



Required fields are indicated with an asterisk (*).

- The supervision effective date cannot be prior to assistant's license effective date.
- The supervisor's license must be within the assistant's practice scope.

Name - Supervisor *	<input type="text" value="Testing Supervisor"/>	<input type="button" value="x"/>
Address - Supervisor		
Street Address Line 1*	<input type="text" value="123 Test Trl"/>	
Street Address Line 2	<input type="text"/>	
City*	<input type="text" value="Green Lake"/>	
State/ZIP*	<input type="text" value="WI"/> <input type="text" value="54941"/> - <input type="text" value="9999"/>	
Telephone Number - Supervisor	<input type="text"/>	Ext. <input type="text"/>
Supervisor's Effective Date*	<input type="text" value="01/01/2015"/>	

Previous

Next

Save & Exit

Wisconsin Medicaid Declaration of Supervision for Nonbilling Providers Affirmation



Required fields are indicated with an asterisk (*).

I affirm that Testing Supervisor is supervising my work as a renderer with Wisconsin Medicaid effective 01/01/2015. If Testing Supervisor discontinues supervision with me, I understand that I must update this information with Wisconsin Medicaid. I understand that I must submit the contact information of my new supervisor prior to continuing work as a renderer with Wisconsin Medicaid.

I Agree I Do Not Agree

Previous

Next

Save & Exit

Screen Shots of ForwardHealth Portal

Attestation

Required fields are indicated with an asterisk (*).

I affirm that I have completed the minimum hours of training and experience required to enroll with ForwardHealth as described in the ForwardHealth Enrollment Criteria for my selected provider type [Link](#). I have and will maintain documentation of all required training and experience. I will submit evidence of my training and experience with my enrollment request and will provide additional documentation to ForwardHealth on request.

I attest.

[Previous](#) [Next](#) [Save & Exit](#)

Upload Supporting Documents

Required fields are indicated with an asterisk (*).

- Upload any supporting documentation needed for enrollment (i.e. licenses, certifications, etc.).
- Select "Browse" to locate each file you wish to upload.
- Select "Upload" when you are ready to upload each file.
- **Please Note:** JPG, JPEG, TXT, RTF, CSV, and PDF file formats are accepted for supporting document uploads.
- Providers enrolling for a Behavioral Treatment Technician will need to upload appropriate certificates, educational degrees with 40 hours of training curriculum and must be 18 years old.

Upload File

File Path [Browse...](#) [Upload](#)

List of Files Uploaded

[Previous](#) [Next](#) [Save & Exit](#)

Screen Shots of ForwardHealth Portal

Summary



- The enrollment request has been completed and is ready to submit. If any changes need to be made, please make them now by using this web site's navigation links and command buttons (not the browser's navigation buttons).
- **IMPORTANT NOTICE:** In receiving this enrollment from and granting Medicaid enrollment to the individual or other entity named as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:
 1. "Provider Applicant" submitted this application or authorized or otherwise caused it to be submitted.
 2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted the "Provider Applicant" will timely notify Wisconsin Medicaid of any such changes.
 3. By submitting this application or causing or authorizing it to be submitted, the "Provider Applicant" agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.
 4. "Provider Applicant" knows and understands the enrollment requirements included in the application materials for the applicable provider types.

If any of the forgoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's enrollment or take other action authorized under ch.HFS106. Wis. Admin. Code or other legal authority governing Wisconsin Medicaid.
- Once you submit the enrollment request, you will be given a tracking number.
- After you submit the enrollment request, you must print and/or save the enrollment record.
- Select "Submit" to submit the enrollment request.

Previous

Submit

Print Enrollment Documents



Required fields are indicated with an asterisk (*).

Before receiving your tracking number you must print or save the enrollment documents. The enrollment documents include the Enrollment Request Report, Provider Agreement and any other documents completed during the online enrollment process. These documents should be retained as record of the applicant's enrollment data submitted to Wisconsin Medicaid. Do not send these documents to Wisconsin Medicaid.

[Print](#) or save the enrollment documents.

After confirming you have printed or saved your document, select Next to complete the enrollment process.

I have printed or saved all enrollment documents

Next

Screen Shots of ForwardHealth Portal



[Provider Certification](#)

[Instructions](#) » [Type of Applicant](#) » [Employed At Clinic](#) » [Type of Enrollment](#)

[Provider Type](#) » [Provider Specialty](#) » [Border Status](#) » [Individual Name](#)

[Practice Location](#) » [Mailing Address](#) » [Prior Authorization Address](#) » [Additional Information](#)

[Medicare/Medicaid Information](#) » [Criminal Conviction/Termination Disclosures](#) » [Owner-Controlling Interest in Other Health Care Providers](#) » [Managing Employee](#)

[Group Member](#) » [Subcontractors and Owner Relationships to Subcontractors](#) » [Wisconsin Medicaid Declaration of Supervision for Nonbilling Providers](#) » [Wisconsin Medicaid Declaration of Supervision for Nonbilling Providers Affirmation](#)

[Attestation](#) » [Upload Supporting Documents](#) » [Summary](#) » [Print Enrollment Documents](#)

[Enrollment Application Submitted](#)

Enrollment Application Submitted



Your Provider Application Request has been submitted.

Application Tracking Number (ATN)

- Your tracking number is 16985

What Needs to be Done Next?

- [Save](#) a copy of the application for your records only. Do not send this application to Wisconsin Medicaid.

Notification of Enrollment Decision

- Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your enrollment. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process. If you are enrolled to provide Medicaid services, you will receive written notice of your approval.

[Previous](#)

[Exit](#)