

## **APPLICATION CHECKLIST FOR INITIAL CREDENTIALING**

*MUCA-This is your application with Wapiti Medical Group. We send it to our facilities as a part of your credentialing file. It is required by 90% of our facilities (including facilities in MN, WI, IA, and SD). Fill out the application out **completely** with all dates, addresses, phone numbers, etc. Please mail documents to the address listed below.*

**Wapiti Medical Group**  
6887 South Lake Avenue  
PO Box 266  
Lake Nebagamon, WI 54849

### **The following forms must be received with original signatures**

- \_\_\_\_\_ Minnesota Uniform Credential Application (MUCA)
- \_\_\_\_\_ Subcontractor Application
- \_\_\_\_\_ Direct Deposit Form
- \_\_\_\_\_ W-9
- \_\_\_\_\_ 855I signature page (print 3, sign all, date none)
- \_\_\_\_\_ 855R signature page (print 3, sign all, date none)

### **Enclose clear, readable, current copies of the following documents**

- \_\_\_\_\_ Federal DEA
- \_\_\_\_\_ State Licenses (All)
- \_\_\_\_\_ State CSR Certificates
- \_\_\_\_\_ Curriculum Vitae
- \_\_\_\_\_ Driver's License
- \_\_\_\_\_ Medical Diploma
- \_\_\_\_\_ Board Certification
- \_\_\_\_\_ Residency Certificate
- \_\_\_\_\_ Internship Certificate
- \_\_\_\_\_ Life Support Certificates
- \_\_\_\_\_ 1-3 Reference Letters
- \_\_\_\_\_ TB/Mantoux Results
- \_\_\_\_\_ 2x3 Photo

# WAPITI MEDICAL GROUP

## Subcontractor Application

Name \_\_\_\_\_ MD or DO \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_

City \_\_\_\_\_ Phone# \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Personal Corporation \_\_\_\_\_ Tax ID # \_\_\_\_\_

Medical School \_\_\_\_\_ Dates \_\_\_\_\_

Residency \_\_\_\_\_ Dates \_\_\_\_\_

Boards \_\_\_\_\_ Dates \_\_\_\_\_

DEA # \_\_\_\_\_ State DEA # \_\_\_\_\_

Malpractice Suits filed \_\_\_\_\_

Will you have your own malpractice insurance? \_\_\_\_\_ (If yes, please include a copy of the certificate).

State Licenses \_\_\_\_\_

Will you need help filing for a state license? \_\_\_\_\_ Which state(s)? \_\_\_\_\_

Any License revocation or restriction \_\_\_\_\_

How many hours are you interested in working each month? \_\_\_\_\_

Are you interested in working at a number of different sites or primarily at a single location? If a single site, do you have a particular site you are interested in? \_\_\_\_\_

### PROFESSIONAL REFERENCES:

1. Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: \_\_\_\_\_

3. Name: \_\_\_\_\_  
Address: \_\_\_\_\_

Phone: \_\_\_\_\_





## SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R. 424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement. The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

### A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., etc. M.D., D.O., etc.
Individual Practitioner Signature ( <i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i> )			Date ( <i>mm/dd/yyyy</i> )
SIGNED			

### B. Authorized or Delegated Official

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., etc. M.D., D.O., etc.
Authorized or Delegated Official's Signature ( <i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i> )			Date ( <i>mm/dd/yyyy</i> )
SIGNED			

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

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**SECTION 15: CERTIFICATION STATEMENT (Continued)**

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First Name	Middle Initial	Last Name	M.D., D.O., etc.
Practitioner Signature (First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)		Date Signed (mm/dd/yyyy)	

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

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**SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)**

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**SECTION 17: SUPPORTING DOCUMENTS**

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This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

**MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES**

- Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.  
**NOTE:** If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)
- Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

**MANDATORY, IF APPLICABLE**

- Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.
- Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.
- Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)
- Copy of current CLIA and FDA certification for each practice location reported.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0685. The time required to complete this information collection is estimated to 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

**DO NOT MAIL APPLICATIONS TO THIS ADDRESS.** Mailing your application to this address will significantly delay application processing.