



Application Request Form

Please type or print

Date: _____

Provider Last Name: _____ Provider First Name: _____

Provider Degree Type (please check):

MD/DO PH.D/PSY D/ED.D MSW/ LCSW RN NPP MA/ MS

In patient Hospital Other: _____

Are you interested in also becoming an EAP provider: Y N

Ages treated: Child (0-12yrs old) Adolescent (13-17yrs old) Other

Languages spoken by provider: _____; by office staff: _____

Are you an outpatient group? (*does more than one practitioner use the same TAX ID number*) Yes No

How do you or your organization bill? UB 92 CMS 1500

Group Name (*if applicable*): _____

Tax Identification Number of Group (*if applicable*): _____

EIN (*if NOT part of a group*): _____

Name as shown on income tax returns: _____

(this may be different than above and is needed to assure proper contracting)

How does the provider file income taxes? (please check) *needed for contracting purposes*

individual/ sole proprietor corporation partnership other: _____

Social Security Number of Provider: _____

Mailing Address: _____

Is this address also the primary address? Yes No

Primary Address (please include county): _____

Contact Person: _____ Phone: (____) _____

Does your group have any of the following accreditations? (Check if yes)

1) Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

2) Commission on Accreditation of Rehabilitation Facilities (CARF)

Submit to:

APS Healthcare, Inc.

P.O. Box 991

Brookfield, WI 53008-0991

Fax Number: 262-787-2364

Or via email at: providerapplicationrequest@apshealthcare.com