

Wisconsin's Family Care Provider Application

Wisconsin | Anthem Blue Cross and Blue Shield | Family Care programs

To start the contracting and certification process, please fill out this application completely and submit it along with all necessary documentation. Applications missing any required information will be considered incomplete and will not be processed.

Note that a separate application is required for each NPI and Tax ID combination.

Acceptance of this enrollment form by Anthem does not guarantee network participation. All requirements related to network participation are governed by Anthem's provider manual(s).

If you have not registered with the Wisconsin Department of Health Services (DHS) by January 1, 2026, we cannot accept your application. Providers must have a valid Wisconsin Medicaid ID number before contracting with Anthem and can only be contracted for waiver services they enrolled with through the DHS. To register with Wisconsin Medicaid, visit the ForwardHealth Portal and ensure you have a signed agreement with the DHS.

Required documents should be provided to Anthem upon completion of this application:

- W-9 Form
- Copy of the current General and Professional Liability Certificate of Insurance forms
- If providing transportation, a copy of the current Auto Liability Certificate of Insurance Form and a copy of the active driver's license

Please submit your completed Family Care Application and certification documents to:
WI-LTSSNetwork@anthem.com

General provider information

Legal name:	DBA name:	Application type: <input type="checkbox"/> New provider <input type="checkbox"/> Adding address/counties/services <input type="checkbox"/> Changing address/counties/services
Tax ID:	NPI:	
Medicaid ID:	Medicare ID:	
Medicaid ID certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	DHS signed agreement: <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity/race: <input type="checkbox"/> African American <input type="checkbox"/> Hispanic/Latino American <input type="checkbox"/> Women <input type="checkbox"/> Native American <input type="checkbox"/> Asian American <input type="checkbox"/> Other: <input type="checkbox"/> Race/ethnicity Directory Listing Opt Out
Minority business: <input type="checkbox"/> Yes <input type="checkbox"/> No	Minority business certified: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Agency website URL:		

Provider primary address:

Street:	City:	State:	ZIP code:
Phone number:	Primary fax number:	Credentialing contact:	Contact title:
Email address:			
Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No Bariatric accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No Memory care: <input type="checkbox"/> Yes <input type="checkbox"/> No High behavioral: <input type="checkbox"/> Yes <input type="checkbox"/> No High medical: <input type="checkbox"/> Yes <input type="checkbox"/> No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate what type and which language:			

Provider payment/remit address:

Street:	City:	State:	Billing ZIP code:
Billing phone number:	Billing fax number:	Billing contact:	Contact title:
Email address:			

Hours of operation:

<input type="checkbox"/> 24 hours	Mon: to	Tues: to	Wed: to	Thurs: to
	Fri: to	Sat: to	Sun: to	

Emergency contact information:

Emergency phone number:	Emergency contact:	Emergency contact title:	Emergency email address:
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Cultural competency (mandatory network requirements):

Did the care provider complete cultural competency training?
 Yes No

Does the care provider require and document cultural competency training annually?
 Yes No

Do your office(s) meet the Americans with Disabilities Act accessibility requirements?
 Yes No

Does the care provider have interpretation services?
 Yes No
 If yes, please indicate what type:

Provider additional locations tied to a licensure (same Tax ID/NPI as primary address):

Location 2:

Street address:	City:	State:	ZIP code:
Phone number:	Fax number:	Administrator name:	
Email address:			
Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No Bariatric accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No Memory care: <input type="checkbox"/> Yes <input type="checkbox"/> No High behavioral: <input type="checkbox"/> Yes <input type="checkbox"/> No High medical: <input type="checkbox"/> Yes <input type="checkbox"/> No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate what type and which language:			

Location 3:

Street address:	City:	State:	ZIP code:
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Phone number:	Fax number:	Administrator name:
Email address:		
Handicap accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No Bariatric accessible: <input type="checkbox"/> Yes <input type="checkbox"/> No Memory care: <input type="checkbox"/> Yes <input type="checkbox"/> No High behavioral: <input type="checkbox"/> Yes <input type="checkbox"/> No High medical: <input type="checkbox"/> Yes <input type="checkbox"/> No If a residential location: number of beds: Does the care provider have any other cultural or linguistic services (including ASL): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate what type and which language:		

*For additional address locations, submit a separate attachment including demographics with the application packet.

Please select the applicable Home and Community-Based Waiver Services qualified to provide:

<input type="checkbox"/> Adult Day Care <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Service Dog <input type="checkbox"/> Competitive Integrated Employment (CIE) Exploration <input type="checkbox"/> Communication Assistance <input type="checkbox"/> Sign Language Interpreter <input type="checkbox"/> Consumer Directed Services Broker <input type="checkbox"/> Consumer Education and Training <input type="checkbox"/> Counseling and Therapeutic Resources <input type="checkbox"/> Licensed services <input type="checkbox"/> Exercise, Diet, and Nutrition <input type="checkbox"/> Daily Living Skills <input type="checkbox"/> Day Habilitation <input type="checkbox"/> Community <input type="checkbox"/> Facility <input type="checkbox"/> Financial Management Services <input type="checkbox"/> Health and Wellness <input type="checkbox"/> Housing Counseling <input type="checkbox"/> Personal Emergency Response System (PERS)	<input type="checkbox"/> Prevocational Services <input type="checkbox"/> Community <input type="checkbox"/> Facility <input type="checkbox"/> Relocation-Community Transition <input type="checkbox"/> Remote Support Monitoring <input type="checkbox"/> Residential Care <input type="checkbox"/> 1-2 Bed Adult Family Home <input type="checkbox"/> 3-4 Bed Adult Family Home <input type="checkbox"/> Community-Based Residential Facility <input type="checkbox"/> Residential Care Apartment Complex <input type="checkbox"/> Respite Care <input type="checkbox"/> Skilled Nursing Services-RN/LPN <input type="checkbox"/> Specialized Medical Equipment and Supplies <input type="checkbox"/> Supported Employment <input type="checkbox"/> Group Setting <input type="checkbox"/> Individual Setting <input type="checkbox"/> Supportive Home Care <input type="checkbox"/> Training for Unpaid Caregivers <input type="checkbox"/> (Non-Emergency) Transportation <input type="checkbox"/> Vehicle Modification <input type="checkbox"/> Vocational Futures Planning and Support
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Please select the applicable Medicaid State Plan - Family Care services qualified to provide. Note: If applying for any of the following services in addition to the Home and Community-Based Waiver services list above, you may be required to complete an HDO Application and additional credentialing/certification documents as determined by Anthem.

<input type="checkbox"/> AODA <input type="checkbox"/> AODA Day Treatment <input type="checkbox"/> Community Support Program <input type="checkbox"/> Disposable Medical Supplies <input type="checkbox"/> Durable Medical Equipment <input type="checkbox"/> Home Health Services <input type="checkbox"/> Mental Health Day Treatment <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Nursing Home (nursing home, institution for mental disease (IMD and ICF-I/DD))	<input type="checkbox"/> Nursing (including Intermittent and Private Duty) <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Personal Care <input type="checkbox"/> Physical therapy <input type="checkbox"/> Respiratory Care <input type="checkbox"/> Speech and Language Pathology <input type="checkbox"/> Transportation
<p>Indicate selected services provided by subcontractor:</p>	

Please select the applicable counties covered, qualified, and capable of serving within:

<input type="checkbox"/> Adams <input type="checkbox"/> Ashland <input type="checkbox"/> Barron <input type="checkbox"/> Bayfield <input type="checkbox"/> Brown <input type="checkbox"/> Buffalo <input type="checkbox"/> Burnett <input type="checkbox"/> Calumet <input type="checkbox"/> Chippewa <input type="checkbox"/> Clark <input type="checkbox"/> Columbia <input type="checkbox"/> Crawford <input type="checkbox"/> Dane <input type="checkbox"/> Dodge <input type="checkbox"/> Door <input type="checkbox"/> Douglas <input type="checkbox"/> Dunn <input type="checkbox"/> Eau Claire <input type="checkbox"/> Florence <input type="checkbox"/> Fond du lac <input type="checkbox"/> Forest <input type="checkbox"/> Grant <input type="checkbox"/> Green <input type="checkbox"/> Green Lake	<input type="checkbox"/> Iowa <input type="checkbox"/> Jackson <input type="checkbox"/> Jefferson <input type="checkbox"/> Juneau <input type="checkbox"/> Kenosha <input type="checkbox"/> Kewaunee <input type="checkbox"/> La Crosse <input type="checkbox"/> Lafayette <input type="checkbox"/> Langlade <input type="checkbox"/> Lincoln <input type="checkbox"/> Manitowoc <input type="checkbox"/> Marathon <input type="checkbox"/> Marinette <input type="checkbox"/> Marquette <input type="checkbox"/> Menominee <input type="checkbox"/> Milwaukee <input type="checkbox"/> Monroe <input type="checkbox"/> Oconto <input type="checkbox"/> Outagamie <input type="checkbox"/> Ozaukee <input type="checkbox"/> Pepin <input type="checkbox"/> Pierce <input type="checkbox"/> Polk <input type="checkbox"/> Portage	<input type="checkbox"/> Price <input type="checkbox"/> Racine <input type="checkbox"/> Richland <input type="checkbox"/> Rock <input type="checkbox"/> Rusk <input type="checkbox"/> Sauk <input type="checkbox"/> Sawyer <input type="checkbox"/> Shawano <input type="checkbox"/> Sheboygan <input type="checkbox"/> St. Croix <input type="checkbox"/> Taylor <input type="checkbox"/> Trempealeau <input type="checkbox"/> Vernon <input type="checkbox"/> Vilas <input type="checkbox"/> Walworth <input type="checkbox"/> Washburn <input type="checkbox"/> Washington <input type="checkbox"/> Waukesha <input type="checkbox"/> Waupaca <input type="checkbox"/> Waushara <input type="checkbox"/> Winnebago <input type="checkbox"/> Wood <input type="checkbox"/> Statewide
<p>If all services do not apply to every county selected above, explain here:</p>		

Attestation questions:

Has the provider had any professional liability claim judgments or settlements?

Yes No

Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced, or not renewed?

Yes No

Has the business been denied participation, suspended from, or denied renewal from Medicare or Medicaid?

Yes No

Has the business ever had its professional liability coverage canceled or not renewed?

Yes No

Has the business been denied accreditation by its selected accrediting body or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?

Yes No

Provider attests that it is in compliance with DHS requirements for Civil Rights/Affirmative Action and has provided Anthem with a Letter of Assurance. In addition, providers with more than 50 employees or receiving more than \$50,000 in government funding must complete a Civil Rights Compliance Plan: <https://www.dhs.wisconsin.gov/civilrights/index.htm>

Yes No

Provider agrees to follow all operational and administrative requirements, including certification/licensure, policies, staff qualifications, member rights, statutes, and quality assurance for services provided to members as defined, but not limited to, the State of Wisconsin Legislature Administrative Codes for the DHS and Anthem's Provider Agreement and provider manual(s).

Yes No

If the answer is "Yes" to any of the above questions, please provide additional details below and/or submit documentation for reasons why you marked Yes:

Attestation and information release authorization:

All information provided in this application or related to it is complete and accurate to the best of my knowledge. I will promptly notify Anthem of any changes. I understand that submitting this application does not guarantee participation with Anthem.

I certify, to the best of my knowledge and belief, that I am not an “Ineligible Provider/Organization.” I also certify, to the best of my knowledge and belief, that my principals and I: (1) are not currently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not, within the three years prior to this application, been convicted of or had a civil judgment rendered against them for committing fraud or a criminal offense related to obtaining, attempting to obtain, or performing a public transaction (Federal, State, or local), violating Federal or State antitrust laws, or committing embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not currently indicted or otherwise criminally charged by a government entity (Federal, State, or local) with the offenses listed in (2); and (4) have not, within the three years prior to this application, had one or more public transactions (Federal, State, or local) terminated for cause or default.

I understand that as an applicant for participation with Anthem, I have the right to review information obtained from primary verification sources during the certification process. I also understand that upon notification from Anthem, I have the right to explain any information obtained that may differ significantly from what I provided, and I have the right to correct any incorrect information submitted by another party. I further understand that I may appeal Anthem’s decision, in writing for reconsideration upon request.

Authorized signature:		
Printed name: (Owner/Registered Authorized Agent)	Signature: (Owner/Registered Authorized Agent)	Date:
Title: (Owner/Registered Authorized Agent)		