



2010 - Wraparound Milwaukee Provider Network
DIRECT SERVICE PROVIDER REQUEST FORM

Entered by: _____
 Date: _____

Date _____ Agency Name _____

Contact Person _____ Phone Number _____ FAX Number _____

NOTE: INCOMPLETE forms and forms that are NOT dated and signed will not be processed.						CREDENTIALS					Wraparound Use Only
(Check Box if NEW STAFF) PRINT Provider Name (Last Name, First Name)	Provider D.O.B.	CHECK IF BILINGUAL	One Service Per Line REQUIRED Service Code	Service Code and Service Name Must Match Service Name	Required for AODA and Mental Health Providers NPI Number	CHECK ONLY IF ATTACHED					
						15 Hr Training Certificate	Wisc. State License	3000 Hour Letter	University/College Degree	Resume or Letter of Recommendation	
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Background checks have been completed on all of the above staff within the last 4 years and are available upon request at the above agency.
 Submit Wisconsin State Dept. of Justice and/or Dept. Regulation and Licensing report to Wraparound for review if criminal record, denial or revocation is noted.

Prepared by: _____

Date: _____