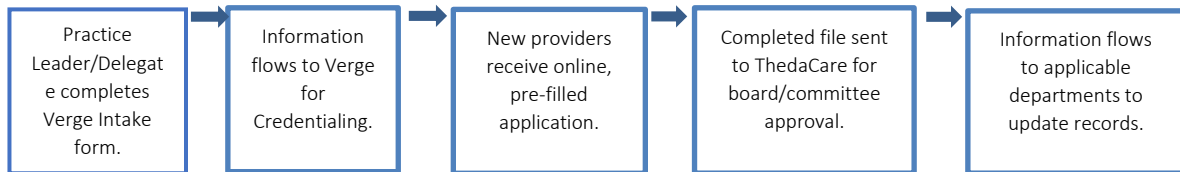


## Verge Credentialing and Practitioner Management Reference Guide

This reference guide outlines the process to be performed by the hiring leader/delegate or practice leader/delegate for new and existing providers.

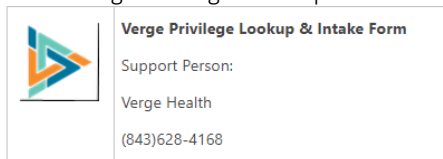
### Process overview:



### Locating and Completing the Intake Form on the ThedaCare Intranet

The form is located on the ThedaCare intranet to ensure proper security provisioning prior to submission.

1. Navigate to the Sharewell home page <https://sharewell.thedacare.org/SitePages/Home.aspx>
2. Across the top navigation bar, click on the “Applications” tab
3. Click on Verge Privilege Look Up & Intake Form



4. Click on *Credentialing Request Form* link at the top of page on the left-hand side. No separate login required.
  - a. No Access to ThedaCare – i.e. non-ACO independent providers? Email request to: [brianne.trantow@thedacare.org](mailto:brianne.trantow@thedacare.org) or [Breanne.Kasuboski@thedacare.org](mailto:Breanne.Kasuboski@thedacare.org)
5. Once you begin, you need to complete the form. You may cancel out of the form but the information will not save.
6. Complete required fields noted as *\*selection required*. Complete other fields that are applicable. The more information you can provide, the better.

### Table of Contents

Over View.....	Page 1
Definitions for Type of Request.....	Page 2
Provider New Request .....	Page 3
Provider Change Request .....	Page 5
Provider Removal Request.....	Page 7
Location New Request .....	Page 8
Location Change Request .....	Page 9
Location Removal Request .....	Page 9
Practice New Request .....	Page 10
Practice Change Request .....	Page 11
Practice Removal Request .....	Page 11
Frequently Asked Questions .....	Page 11
Who to Contact with Questions .....	Page 12

## Review the Below Definitions Prior to Submitting A Form

### Data Definitions for Type of Request:

**Practice:** Entire group with multiple locations utilizing same TIN/NPI/Billing Address

**Location:** Site of service within the practice

#### Provider - New:

- \* Adding a new provider to your practice/location
- \* Requesting privileges at a hospital where the provider is not yet affiliated
- \* Requesting payer credentialing

**Provider - Change:** Changing existing provider demographics or locations

- \* Change provider name
- \* Change title or specialty
- \* Add a location

**Provider - Removal:** Provider is leaving a practice/location or removing hospital privileges

- \* Remove Hospital privileges
- \* Remove Provider from entire practice
- \* Remove Provider from a location
- \* Withdraw Application/Provider no longer coming

**Location - New:** Adding a new location to an existing tax id and organizational NPI. Please allow up to 2 weeks after request for new location to show in drop down lists.

**Location - Change:** Changing a location within a practice. Please allow up to 2 weeks after request for location update to show in drop down lists.

**Location - Removal:** Eliminating a location within a practice

**Practice - New:** Adding a new practice with new billing address/NPI/TIN. Please allow up to 2 weeks after request for new practice to show in drop down lists.

**Practice - Change:** Changes all locations within a practice. Please allow up to 2 weeks after request for practice update to show in drop down lists.

**Practice - Removal:** Removing all locations within a practice

## Type of Request: Provider New

- Adding a new provider to your practice/location
- Requesting privileges at a hospital where the provider is not yet affiliated
- Requesting payer credentialing

### Requester Information

First Name:  \* Required  
Last Name:  \* Required  
Requester Title:  \* Required  
Requester Email Address:  \* Required

### Office Credentialing Contact Information

\*Office Contact Name:  \* Required  
\*Office Contact Email:  \* Required  
\*Office Contact Phone (Numerical Values Only ex. 9208752323):  \* Required  
Additional Contact Name:   
Additional Contact Email:   
Additional Contact Phone (Numerical Values Only ex. 9208752323):

### Provider/Applicant:

Select Staff Member | Reset

\* Selection required

New Provider or Provider Not Found

### Provider/Applicant SSN and Date of Birth:

SSN:  \* Required  
Date of Birth:  \* Required

### Provider/Applicant:

New Provider or Provider Not Found

### Provider/Applicant Name:

First Name:  \* Required  
Middle Name:  \* Required  
Last Name:  \* Required

### Provider/Applicant Information:

Suffix:  \* Required  
Email Address:  \* Required  
Degree:  \* Required  
\*SSN:  \* Required  
Gender:  Male  Female  Unknown

\* Selection Required

NPI:   
DEA #:   
License #:

### Provider Title:

<input type="checkbox"/> OD	<input type="checkbox"/> MSSW
<input type="checkbox"/> DPM	<input type="checkbox"/> CST
<input type="checkbox"/> MD	<input type="checkbox"/> SAC
<input type="checkbox"/> APNP	<input type="checkbox"/> CNM
<input type="checkbox"/> PT	<input type="checkbox"/> LMFT
<input type="checkbox"/> PA	<input type="checkbox"/> CNM/APNP
<input type="checkbox"/> LCSW	<input type="checkbox"/> MSW
<input type="checkbox"/> LPC	<input type="checkbox"/> PHD
<input type="checkbox"/> CRNA	<input type="checkbox"/> CFA
<input type="checkbox"/> AUD	<input type="checkbox"/> OTR
<input type="checkbox"/> DO	<input type="checkbox"/> RN
<input type="checkbox"/> CSAC	<input type="checkbox"/> LPC-IT
<input type="checkbox"/> DC	<input type="checkbox"/> DA
<input type="checkbox"/> PSYD	<input type="checkbox"/> DDS
<input type="checkbox"/> RD	<input type="checkbox"/> DMD
<input type="checkbox"/> OT	<input type="checkbox"/> Other (Please Specify): <input type="text"/>

**Requestor Information** is the name of the person completing the form.

### Office Credentialing Contact Information

- Office Contact Name/Email/Phone is the point person in **your** office who will assist the provider with current and future Credentialing requests within ThedaCare.
- Additional Contact Name/Email/Phone is an additional point person in **your** office who will assist the provider with current and future Credentialing requests within ThedaCare.

**Provider Applicant** click on "Select Staff Member" to Search for provider. If provider name is found move on to next section. If provider not found, select New Provider or Provider Not Found and complete Provider/Applicant sections.

**Note:** SSN & DOB are required fields. Your request will not be approved if this information is not provided.

**Anticipated Start Date (minimum of 60 days from current date):**

\*  \* Required

**Languages Spoken:**

Primary:

Other Language (1):

Other Language (2):

**Type of Provider (check all applicable answers):**

- ThedaCare - Employed
- ThedaCare - Employed Resource Team
- ThedaCare - Contracted/Locum
- Independent - ACO
- Independent - PHI (Premium Healthcare)
- Independent - ACO Locum
- Independent - PHI Locum
- Independent - Not ACO or PHI
- Independent - Locum

\* Please select at least 1 answer

**Requesting Privileges at (check all applicable answers):**

- ThedaCare Regional Medical Center Appleton Inc
- ThedaCare Regional Medical Center Neenah Inc
- ThedaCare Medical Center Waupaca Inc
- ThedaCare Medical Center Shawano Inc
- ThedaCare Medical Center New London Inc
- ThedaCare Medical Center Berlin Inc
- ThedaCare Medical Center Wild Rose Inc
- Not requesting hospital privileges

\* Please select at least 1 answer

**Please upload CV**

No file chosen  
Max File Size = 20.00 MB

**Please upload a copy of the provider's drivers license or government issued ID**

No file chosen  
Max File Size = 20.00 MB

**Primary Specialty/Taxonomy:**

\* Selection required

**Primary Practice (Name-TIN-Organizational NPI):**

- The Eye Clinic of the Fox Valley SC-391353462-1003925892
- The Kagen Allergy Clinic SC-800804857-1770843260
- The Medical College of Wisconsin Inc-390806261-1699720086
- ThedaCare ACO LLC-465613105-1033519046
- ThedaCare at Home-391509362-1295823508
- ThedaCare at Work-391509362-1063569002
- ThedaCare Behavioral Health-391509362-1306959515
- ThedaCare Medical Center Berlin Anesthesia-390806359-1275943367
- ThedaCare Medical Center Berlin Inc DBA Juliette Manor-390806359-1023154929
- ThedaCare Medical Center Berlin Inc-390806359-1760413777
- ThedaCare Medical Center New London Inc-390869788-1538127220
- ThedaCare Medical Center Shawano Inc-390807068-1548260839
- ThedaCare Medical Center Waupaca Inc-390871113-1013995521
- ThedaCare Medical Center Wild Rose Inc-396089134-1043263999
- ThedaCare Medical Center Orthopedics Spine and Pain-390824015-1740920909
- ThedaCare Physicians and Specialty Professional Services-391509362-1376656959
- ThedaCare Regional Medical Center Appleton Inc-390824015-1902832306
- ThedaCare Regional Medical Center Neenah Inc-390830664-1518993880
- ThedaCare Rural Health Clinic Clintonville
- ThedaCare Rural Health Clinic Shawano

**Anticipated Start Date (minimum of 60 days from current date)** For new providers, please be aware the process takes approximately 60 days **after** the provider completes their application online.

**Utilize the New Credentialing Calculator each time a provider is being recruited and is intending to apply for appointment at any of the hospitals within the ThedaCare System.**

[Credentialing Calculator](#)

**Type of Provider (check all applicable answers)**

**Requesting Privileges at (Check all applicable answers)**

**Upload CV – Required**

**Upload Driver’s License or Government Issued ID – Required**

**Note:** CV & Driver’s License are required fields. Your request will not be approved if this information is not provided.

**Provider’s Primary Specialty/Taxonomy** select appropriate specialty/taxonomy. If applicant is a Nurse Practitioner select Nurse Practitioner, if applicant is a Physician Assistant select Physician Assistant.

**Primary Practice** Select primary practice. This is the billing Tax ID & NPI.

ThedaCare employed specialties such as: cardiologist, hospitalist, intensivist, orthopedist, etc. select **ThedaCare Physicians and Specialty Professional Services.**

**Primary Location Add (Provider-New) - This is the location that will be listed in payor directory where the majority of time is spent:**

Please Select ▼

*\* Selection required*

**Primary Location Add (Provider-New)** Select the location the provider will be spending the majority of their time working. This will be the Primary Contact address listed in Verge and payor directory.

- Type of Request: Provider Change**
- Change provider name
  - Change title or specialty
  - Add a location
  - Add a practice
  - Misc. Request

**Change Provider Name:**

**Type of Provider change:**

Change a provider name  
 Change a title or specialty  
 Add a location  
 Add a practice

*\* Please select at least 1 answer*

**Effective date of change request**

\* Required

**Name Change Information**

New First Name:  \* Required  
New Middle Name:  \* Required  
New Last Name:  \* Required

**Has the provider formally updated their state license, DEA, NPI, Driver's License, and SSN?**

Yes  No

*\* Selection Required*

**Please provide a copy of updated medical and drivers license to submit to Medicare.**

No file chosen  
Max File Size = 20.00 MB

**Additional Change Request Notes (Please list the specialty with each corresponding location):**

Select this form AND complete an IS security form for all changes

NPI, DEA, State License, SSN and Driver's License must be updated prior to completing and submitting this form. If updates have not been made, do not submit the form at this time.

**Note:** Medical License and Driver's License are required fields. Your request will not be approved if this information is not provided.

**Change a Title or Specialty:**

**Type of Provider change:**

Change a provider name  
 Change a title or specialty  
 Add a location  
 Add a practice

*\* Please select at least 1 answer*

**Effective date of change request**

\* Required

**Provider New Title:**

\* Required

**What is the Provider's Primary Specialty?**

Please Select ▼

*\* Selection required*

**Specialties to be removed (check all applicable answers):**

Accountable Care     Hearing Aid Supplier     Ophthalmology

**Specialties to be added (check all applicable answers):**

Accountable Care     Hearing Aid Supplier     Ophthalmology

Complete required and all applicable fields

**Add a Location:**

**Type of Provider change:**

Change a provider name  
 Change a title or specialty  
 Add a location  
 Add a practice  
*\* Please select at least 1 answer*

**Effective date of change request**

\* Required

**Practice that location needs to be added to (Provider-Change) (Name-TIN-Organizational NPI):**

Please Select

*\* Selection required*

**Location(s) to be added (check all applicable answers):**

Advanced Family   
  Ear Nose & Throat   
  Neuroscience Group of   
  Sherman Counseling   
  T

Select this option if Provider is providing services at an additional location within the same Practice.

**Note:** If provider is hospital based and will be providing services at a clinic a Provider New form is required for Payer Credentialing.

**Note:** If hospital privileges are needed or privileges are needed at additional hospitals – Provider New Form required.

**Add a Practice:**

**Type of Provider change:**

Change a provider name  
 Change a title or specialty  
 Add a location  
 Add a practice  
*\* Please select at least 1 answer*

**Effective date of change request**

\* Required

**Practice that needs to be added:**

Please Select

*\* Selection required*

**Will this practitioner still be with their previous practices?**

Yes  No

**Will this change require new malpractice coverage?**

Yes  No

**Will this change require a change in specialty?**

Yes  No

**Will this change require any changes in privileges?**

Yes  No

**If Allied Health or APC, will this change require a change in supervising/collaborating physician?**

Yes  No

**Additional Change Request Notes (Please list the specialty with each corresponding location):**

Select this option when adding an additional Practice or leaving current Practice. Complete all selections.

**Will this change require new malpractice insurance?**  
 - Upload new malpractice coverage

**Misc. Request:**

**Type of Provider change:**

Change a provider name  
 Change a title or specialty  
 Add a location  
 Add a practice  
 Misc. Request  
*\* Please select at least 1 answer*

**Effective date of change request**

*\* Required*

**Is the provider not listed in directory?**

Yes  No

**Miscellaneous Requests**

Use for payer directory, payer enrollment, payer credentialing issues

**Type of Request: Provider Removal**

- Remove **Hospital** privileges
- Remove **Provider** from entire practice
- Remove **Provider** from a location
- Withdraw Application/Provider no longer coming

**Remove Privileges:**

**Type of Provider - Removal Request (check all applicable answers):**

Remove Hospital Privileges  
 Remove Provider from Entire Practice  
 Remove Provider From a Location  
 Withdraw Application/Provider no longer coming  
*\* Please select at least 1 answer*

**Effective date for Provider - Removal request:**

*\* Required*

Primary MSO Contact	Official HCO Name	MSO Direct Phone #	MSO Contact Email
Robin Mitchell	ThedaCare Medical Center- Berlin Hospital Credentialing	920-454-5655	<a href="mailto:Robin.Mitchell@thedacare.org">Robin.Mitchell@thedacare.org</a>
Laura Pavwoski	ThedaCare Medical Center- New London Hospital Credentialing	N/A	<a href="mailto:Laura.Pavwoski@thedacare.org">Laura.Pavwoski@thedacare.org</a>
Kathy Kuse	ThedaCare Medical Center- Shawano Hospital Credentialing	715.526.7320	<a href="mailto:Kathryn.Kuse@thedacare.org">Kathryn.Kuse@thedacare.org</a>
Valerie Ward	ThedaCare Medical Center- Waupaca Hospital Credentialing	715.258.1056	<a href="mailto:Valerie.Ward@thedacare.org">Valerie.Ward@thedacare.org</a>
Robin Mitchell	ThedaCare Medical Center- Wild Rose Hospital Credentialing	920-454-5655	<a href="mailto:Robin.Mitchell@thedacare.org">Robin.Mitchell@thedacare.org</a>
Lisa Sorenson	ThedaCare Regional Medical Center- Appleton Neenah Hospital Credentialing	920.454.5775	<a href="mailto:lisa.sorenson@thedacare.org">lisa.sorenson@thedacare.org</a>

If provider is only removing hospital privileges, contact the appropriate Medical Staff Office.

TCB & TCW –  
[Valerie.Ward@thedacare.org](mailto:Valerie.Ward@thedacare.org)  
 TCNL & TCWR –  
[Laura.Pavwoski@thedacare.org](mailto:Laura.Pavwoski@thedacare.org)  
 TCS –  
[Kathryn.Kuse@thedacare.org](mailto:Kathryn.Kuse@thedacare.org)  
 TCA/N –  
[Lisa.Sorenson@thedacare.org](mailto:Lisa.Sorenson@thedacare.org)

**Remove from Entire Practice:**

**Type of Provider - Removal Request (check all applicable answers):**

Remove Hospital Privileges  
 Remove Provider from Entire Practice  
 Remove Provider From a Location  
 Withdraw Application/Provider no longer coming  
*\* Please select at least 1 answer*

**Effective date for Provider - Removal request:**

*\* Required*

**Practice(s) to be removed (check all applicable answers):**

Advanced Family  Evelyn LLC 611750488  Jensen Chiropractic

Select this option when provider is leaving/resigning or retiring from your Independent Practice or ThedaCare.

Select this option if provider is clinic/PHO only

**Remove from a Location:**

<p><b>Type of Provider - Removal Request (check all applicable answers):</b></p> <p><input type="checkbox"/> Remove Hospital Privileges</p> <p><input type="checkbox"/> Remove Provider from Entire Practice</p> <p><input checked="" type="checkbox"/> Remove Provider From a Location</p> <p><input type="checkbox"/> Withdraw Application/Provider no longer coming</p> <p><i>* Please select at least 1 answer</i></p> <p><b>Effective date for Provider - Removal request:</b></p> <p><input type="text"/> <small>* Required</small></p> <p><b>Location(s) to be removed (check all applicable answers):</b></p> <p><input type="checkbox"/> Advanced Family    <input type="checkbox"/> Ear Nose &amp; Throat    <input type="checkbox"/> Neuroscience Group of</p>	<p>Select this option when provider is discontinuing services at a location within the current practice.</p> <p><b>Example:</b> provider is no longer providing services at ThedaCare Physicians Neenah, but continuing services at ThedaCare Physicians Oshkosh.</p>
---	---

**Withdraw Application/Provider no Longer Coming:**

<p><b>Type of Provider - Removal Request (check all applicable answers):</b></p> <p><input type="checkbox"/> Remove Hospital Privileges</p> <p><input type="checkbox"/> Remove Provider from Entire Practice</p> <p><input type="checkbox"/> Remove Provider From a Location</p> <p><input checked="" type="checkbox"/> Withdraw Application/Provider no longer coming</p> <p><i>* Please select at least 1 answer</i></p> <p><b>Effective date for Provider - Removal request:</b></p> <p><input type="text"/> <small>* Required</small></p> <p><b>Additional Provider - Removal Request Notes:</b></p>	<p>Select this option when a provider is currently in process for credentialing and is no longer proceeding with credentialing.</p> <p>If provider is withdrawing application at one Hospital and not another, list which hospitals in Notes section.</p>
--	---

These request types below are intended for location level requests applicable to all associated providers. A location is a site of service within a practice with the same billing address, tax id, organizational NPI. **Use to add a new location to a practice.** Use this if the billing address, tax ID, and organizational NPI is the same as the practice information.

**Type of Request: Location New**

- Adding a new location to an existing tax ID and organizational NPI. Allow up to 2 weeks after request for new location to show in drop-down lists.

<p><b>Practice that location needs to be added to:</b></p> <p>Please Select <input type="text"/></p> <p><i>If practice is not found, please complete the "Practice - New" request form</i></p> <p><b>New Location Information:</b></p> <p>Location Name (No Punctuation): <input type="text"/></p> <p>Address: <input type="text"/></p> <p>City: <input type="text"/></p> <p>State: <input type="text"/></p> <p>Zip: <input type="text"/></p> <p>Phone # (Numerical Values Only ex. 9208752323): <input type="text"/></p> <p>Fax # (Numerical Values Only ex. 9208752323): <input type="text"/></p> <p>Location NPI <input type="text"/></p> <p>Scheduling/Appointment Phone Number(Numerical Values Only ex. 9208752323): <input type="text"/></p> <p><b>Location - New Effective Date:</b></p> <p><input type="text"/> <small>* Required</small></p> <p><b>Additional Location - New Request Notes (please list all providers associated with this new location):</b></p> <p><input type="text"/></p>	<p><b>Note:</b> This is not Provider specific. This form is not to be used to add an additional location for a provider.</p> <p><b>Additional Location – New Request Notes:</b> List all <b>current</b> credentialed providers you want to associate with this new location. <b>This is required for the convenience of not having to submit a form for each provider.</b></p>
---	--



### Type of Request: Location Change

- Changing a location within a practice. Please allow up to 2 weeks after request for location update to show in drop-down lists.

**Location to be changed:**  
Please Select

\*Selection required

**New information for selected location:**

\*New Name (No Punctuation):  \*Required

New Directory Name:  \*Required

New Address:  \*Required

New City:  \*Required

New State:  \*Required

\*New Zip:  \*Required

\*New Phone: (Numerical Values Only ex. 9208752323):  \*Required

\*New Fax: (Numerical Values Only ex. 9208752323):  \*Required

Location NPI:

Scheduling/Appointment Phone Number(Numerical Values Only ex. 9208752323):

**Location - Change Effective Date:**  
 \*Required

**Additional Location - Change Request Notes (please list all providers associated with this location change):**

Click on the drop-down arrow and identify the associated location to be changed.

Complete all required fields for the selected location.

**Additional Location – Change Request Notes:** List all **current** credentialed providers you want to associate with this new location. **This is required for the convenience of not having to submit a form for each provider.**

### Type of Request: Location Removal

- Eliminating a location within a practice

**Practice that location needs to be removed from:**  
Please Select

**Location to be removed from practice:**  
Please Select

**Location - Removal Effective Date:**

**Additional Location - Removal Request Notes:**

Click on the drop-down arrow and identify the appropriate location to be removed.

Complete all required fields for the selected location.

**Example:** Women’s Care of WI is closing Berlin location but other locations remain open.

These request types are intended for practice level requests applicable to all associated locations within the practice. A practice may have several locations. **Use to add a new practice with new tax id, organizational NPI, or billing address.**

**Type of Request: Practice New**

- Adding a new practice with new billing address/NPI/TIN. Allow up to 2 weeks after request for new practice to show in drop-down lists.

**New Practice Information**

Legal Name:  \* Required

Tax ID:  \* Required

Organizational NPI:  \* Required

Physical Street Address:  \* Required

City:  \* Required

State:  \* Required

\*Zip:  \* Required

\*Phone #: (Numerical Values Only ex. 9208752323):  \* Required

\*Fax #: (Numerical Values Only ex. 9208752323):  \* Required

**Practice Billing Information**

Billing Contact Name:

Billing Street Address:

City:

State:

Zip:

Billing Phone #: (Numerical Values Only ex. 9208752323):

Billing Fax #: (Numerical Values Only ex. 9208752323):

Billing Email Address:

**Practice Manager Information**

Name:  \* Required

Practice Manager Street Address:  \* Required

City:  \* Required

State:  \* Required

\*Zip:  \* Required

\*Practice Manager Phone #: (Numerical Values Only ex. 9208752323):  \* Required

\*Practice Manager Fax #: (Numerical Values Only ex. 9208752323):  \* Required

Practice Manager Email Address:  \* Required

**Does practice accept medicaid?**

Yes  No

*\* Selection Required*

**Does practice accept medicare?**

Yes  No

*\* Selection Required*

**Practice - New Effective Date:**

**Do you need to add new locations to this practice?**

Yes  No

**Additional Practice - New Request Notes (please list all providers associated with this new practice):**


Complete all fields within this form.

**Do you need to add new locations to this practice:**  
Yes, add new locations associated with the new practice. **This is required for the convenience of not having to submit a form for each location.**

**Additional Practice – New Request Notes:** List all **current** credentialed providers you want to associate with this new practice. **This is required for the convenience of not having to submit a form for each provider.**

### Type of Request: Practice Change

- Changes all locations within a practice. Allow up to 2 weeks after request for practice update to show in drop-down lists.

**Practice for change:**  
Please Select    
\* Selection required

**New/Changing Practice Information**

New Name:  \* Required

\*New Phone #: (Numerical Values Only ex. 9208752323):  \* Required

\*New Fax #: (Numerical Values Only ex. 9208752323):  \* Required

New Tax ID:  \* Required


New Billing Street Address:  \* Required

New City:  \* Required

New State:  \* Required

\*New Zip:  \* Required

**Do you need to add/change a practice manager/contact for this practice?**  
 Yes  No  
\* Selection Required

**Effective date of Practice - Change request:**  
  \* Required

**Additional Practice - Change request notes (please list all providers associated with this practice change):**

Use when you need to make a name, billing address, tax ID/NPI change to your current practice.


Click on the drop-down arrow and identify the associated practice to be changed.


Complete all required fields for the selected practice.

**Additional Practice – Change Request Notes:** List all **current** credentialed providers you want to associate with this new practice. **This is required for the convenience of not having to submit a form for each provider.**

### Type of Request: Practice Removal

- Removing all locations within a practice

**Practice for removal:**  
Please Select    
\* Selection required

**Effective date of Practice - Removal request:**  
  \* Required

**Additional Practice - Removal request notes**

Use when removing an entire practice including all associated locations.

**Example:** Valley Eye Associates purchased Fox Cities Eye Clinic. Completing this form will remove the practice from the intake form drop down list.

Click on the drop-down arrow and identify the associated practice to be removed.

Complete all required fields for the selected practice.

### Frequently Asked Questions

#### Why is the Verge Credentialing Intake Form important?

1. A fully electronic solution saves time and eliminates the need for redundant, inaccurate, time-consuming paper forms, e-mails and faxes.
2. Intake form routes the information to several departments that need to make updates for accuracy in provider directories, payer directories, claim payment, and overall data base integrity.
3. The data set meets the data collection requirements of the National Committee for Quality Assurance (NCQA) and Joint Commission standards.
4. Streamlined communication to stakeholders throughout the process. Requestor will be notified when credentialing file is sent to board/committee for approval and upon approval.
5. Communication of changes such as provider demographic, location, or practice updates.

#### How do I access the intake form if my clinic does not have access to Sharewell?

Email request to: [Brianne.trantow@thedacare.org](mailto:Brianne.trantow@thedacare.org) or [Breanne.Kasuboski@thedacare.org](mailto:Breanne.Kasuboski@thedacare.org)

#### Who should complete the Intake Form?

The individual at the requesting facility/clinic that will be assisting the provider thru the credentialing process or maintaining updates.

Who to Contact?	For:
Verge Health Support Email: <a href="mailto:convergesupport@vergehealth.com">convergesupport@vergehealth.com</a> Phone: (843) 628-4128, Option 2	Technical assistance for completing the Request Form
Verge Health Support Email: <a href="mailto:credentialingsupport@vergehealth.com">credentialingsupport@vergehealth.com</a> Phone: (843) 628-4128, Option 1 Fax: (888) 455-7886	Technical assistance for providers Completing the application
Your Local <a href="#">Medical Staff Office</a>	For Privilege changes
Brienne Trantow or Breanne Kasuboski Medical Staff Services Department <a href="mailto:Brienne.trantow@thedacare.org">Brienne.trantow@thedacare.org</a> <a href="mailto:Breanne.Kasuboski@thedacare.org">Breanne.Kasuboski@thedacare.org</a>	Questions regarding getting access to intake form or completing intake form.
Provider Enrollment <a href="mailto:credentialingverificationoffice@thedacare.org">credentialingverificationoffice@thedacare.org</a>	Questions regarding Medicaid/Medicare
Kris Froemming ThedaCare ACO & Premium Healthcare <a href="mailto:Kris.Froemming@thedacare.org">Kris.Froemming@thedacare.org</a>	Questions regarding ACO/PHI
Jennifer Glasheen Payer Credentialing Director <a href="mailto:Jennifer.Glasheen@thedacare.org">Jennifer.Glasheen@thedacare.org</a>	Questions regarding Payer/clinic credentialing
Robin Mitchell Medical Staff Services Manager <a href="mailto:Robin.Mitchell@thedacare.org">Robin.Mitchell@thedacare.org</a>	Questions regarding Hospital privileging/credentialing