WISCONSIN MEDICAID
OUT-OF-STATE PROVIDER DATA SHEET

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid administration such as determining the certification of providers or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

The use of this form is voluntary. However, in order to be certified, you must complete this form and submit it to the address indicated.

INSTRUCTIONS: Complete this data sheet for whomever performed or will perform medical services on a Wisconsin Medicaid recipient. This is required in order to submit claims for prior authorized or emergency services. **Attach the completed prior authorization or claim to this data sheet.**

In order to be reimbursed for services provided, Wisconsin Medicaid must receive correct and complete claims, including resubmissions and adjustments, within 365 days from the date the service was rendered.

Note: For a provider to bill for services, the provider must submit to Wisconsin Medicaid copies of the provider's current license(s), approval(s), or certification(s). (See indicators in "Key" and "Materials to be Submitted with Data Sheet" columns on reverse side of data sheet for requirements.) Attach required copies to this data sheet.

1. Name — Provider	2. Telephone Number — Provider

3. Address — Provider (where services are rendered)

4. Name — Payee (to whom checks are made payable)

5. Address — Payee (where checks are to be sent)

6. Payee's:
- ❑ Federal Identification / IRS number ___ ___ - ___ ___ ___ ___ ___ ___ ___
- ❑ Social Security Number ___ ___ ___ - ___ ___ -___ ___ ___ ___

7. Please indicate provider type / specialty by circling the correct description(s) on the reverse side of data sheet, or explain your services in detail if not listed.

8. Medicare Number	9. Medicaid Number	10. Number of Beds (for hospital only)	11. UPIN	12. CLIA Number

I affirm that services provided are medically indicated and necessary to the patient's health. The services are within the scope of my (our) licensure. I understand that any false claims, settlements, documents, or concealment of material fact may be prosecuted under applicable federal and state law. I further affirm that to the best of my knowledge the information presented here is accurate and complete.

SIGNATURE — Provider or Authorized Agent of Institution	Date Signed

KEY
Attach to data sheet the required copies as indicated:
A = Copy of license covering date of service.
B = Copy of Medicare certification approval.
C = Copy of approvals/certifications from appropriate associations and organizations (e.g., ASHA, ABC).
D = Copy of approval by Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

INSTRUCTIONS: Circle the provider type and indicate the specialty where applicable for the applicant.

TYPES / SPECIALTIES	MATERIALS TO BE SUBMITTED WITH DATA SHEET
25. Ambulance Providers, Land or Air	A
70. Ambulatory Surgery Centers	B
43. Anesthesiologist Assistants / Certified Registered Nurse Anesthetist (not an M.D.)	A
37. Audiologists	C
30. Chiropractors	A
27. Dentists	A
73. End Stage Renal Disease Service Providers	B
84. Hearing Instrument Specialists	A
44. Home Health Agencies	B
95. Hospice Providers	B
58. Individual Medical Supply Providers) _____ (e.g., Individual Orthotist, Individual Prosthetist	C
61/62. Inpatient or Outpatient Hospital Providers	A, & B or D
64. Institutes for Mental Disease Providers	A
23/69. Laboratory / Independent Labs	B
31/62. Licensed Psychologist (with doctoral degree)	A
54. Medical Equipment Vendors	C
45. Nurse Practitioners	A & C
33. Nurse Services, Specialty _____ (e.g., RN, LPN, Respiratory Care)	A
80. Nursing Home. ❑ Skilled, or ❑ Institution for Mental Disease	A
35. Occupational Therapy	A
29. Optician	C
28. Optometrist	A
19. Osteopath, Specialty _____ (e.g., General Practice, Psychiatry. If specialty is psychiatry, send proof of completed residency.)	A
26. Pharmacies (attach store license)	A
34. Physical Therapists	A
23/66. Physician Clinical Lab	A
20. Physician (M.D.) _____ (e.g., General Practice, Psychiatry. If specialty is psychiatry, send proof of completed residency.)	A
32. Podiatrists	A
75. Portable X-ray Providers	B
65. Rehabilitation Agencies	B
36. Speech & Hearing Clinics	C
78. Speech Language Pathologists (B.S. or M.S. degree)	C

Other. Explain below, and submit applicable required materials (A-D) or your state's requirements.

DISTRIBUTION — Submit completed form with attachments to:

Wisconsin Medicaid
Out-of-State Claims
6406 Bridge Rd
Madison WI 53784-0007

Reset Form