

WISCONSIN MEDICAID OUT-OF-STATE PROVIDER DATA SHEET COMPLETION INSTRUCTIONS

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

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 mandatory to receive prior authorization or reimbursement.

INSTRUCTIONS

Complete the Out-of-State Provider Data Sheet, F-11001, for whomever performed or will perform medical services on a Wisconsin Medicaid member. This is required in order to submit claims for prior authorized or emergency services. **Attach the completed Prior Authorization Request Form, F-11018, or claim to the Out-of-State Provider Data Sheet.** Submit the completed form with attachments to the following address:

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

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 provided.

Note: For a provider to submit claims for services, the provider is required to submit copies of the provider's current license(s), approval(s), or certification(s) to Wisconsin Medicaid. (See the indicators in the "Key" and "Materials to Be Submitted with Data Sheet" column on the last page of this data sheet for requirements.) Attach required copies to the Out-of-State Provider Data Sheet.

All elements are required unless otherwise indicated.

Reason for Sending Out-of-State Provider Data Sheet

Check the appropriate reason for completing and sending this Out-of-State Provider Data Sheet.

SECTION I — PRACTICE LOCATION INFORMATION

A practice location is the street address where a provider's office is physically located and where the records are normally kept.

Element 1 — Name — Provider

Enter the individual provider's first name, middle initial, and last name or the name of the clinic or facility.

Element 2 — Provider ID

This is a required field for health care providers. Health care providers, as defined by the Centers for Medicare and Medicaid Services, will enter their National Provider Identifier (NPI). Non-healthcare providers will enter their eight or nine-digit Wisconsin Medicaid number. Do not enter any other numbers or letters. Non-healthcare providers who do not have a Wisconsin Medicaid number should leave this element blank.

Elements 3-7 — Address

Enter the provider's complete practice location address (street, city, state, and ZIP+4 code). This address is the location where services are primarily provided.

Element 8 — Gender

Enter the individual provider's gender.

Elements 9 and 10 — Name and Telephone Number — Contact Person

Enter the contact person and the telephone number for the contact person. The contact person's information is required for Wisconsin Medicaid administrative purposes only.

SECTION II — PROVIDER FINANCIAL INFORMATION

Wisconsin Medicaid will generate payments to the provider and report income to the Internal Revenue Service (IRS) using this information. This information must be the current taxpayer information on file with the IRS.

Taxpayer Information

Element 11 — Taxpayer Identification Number (TIN)

Enter the TIN that should be used to report income to the IRS.

Element 12 — Name — Taxpayer

Enter the taxpayer's name for the TIN indicated in Element 11. The name entered must be the same name that is on file with the IRS.

Element 13 — TIN Type

Indicate whether the TIN indicated in Element 11 is an Employer Identification Number (EIN) or a Social Security number (SSN).

Element 14 — TIN Effective Date

Enter the effective date of the TIN.

Element 15 — TIN End Date

Enter the end date of the TIN.

Checks and Remittance Advice Information

Elements 16-20 — Address

Enter the complete address to which checks and Remittance Advices should be mailed.

Elements 21-22 — Name and Telephone Number — Financial Contact Person

Enter the financial contact person's name and telephone number.

IRS Form 1099 Mailing Address

IMPORTANT: Only one 1099 will be sent per TIN. If the provider completing this form is not responsible for receiving the 1099, the provider should not complete this section.

Elements 23-27 — IRS Form 1099 Mailing Address

Enter the complete address to which the IRS Form 1099 should be sent. (Enter either a P.O. Box or street address [include a suite number, if applicable], city, state, and ZIP+4 code).

SECTION III — MAILING INFORMATION

Indicate the address where Wisconsin Medicaid should send general information and correspondence.

Element 28 — Name — Mail To

Enter the first name, middle initial, last name, or the name of the office, clinic, facility, or place of business for the mailing address.

Element 29 — Name — Attention Line

Enter attention line information that Wisconsin Medicaid should use for mailing general information and correspondence.

Elements 30-34 — Mailing Address

Enter the provider's complete mailing address (enter either a P.O. Box or street address [include a suite number, if applicable], city, state, and ZIP+4 code).

SECTION IV — PRIOR AUTHORIZATION INFORMATION

Indicate the address where Wisconsin Medicaid should send prior authorization (PA) information.

Element 35 — Name — Provider

Enter the first name, middle initial, last name, and title or the name of the office, clinic, facility, or place of business for the PA address.

Element 36 — Name — Attention Line

Enter the attention line information that Wisconsin Medicaid should use for mailing PA information.

Elements 37-41 — Address

Enter the provider's complete PA address. (Enter either a P.O. Box or street address [include a suite number, if applicable], city, state, and ZIP+4 code).

Elements 42 — Fax Number

Enter the fax number.

Elements 43 — Telephone Number — Contact Person

Enter the telephone number for the contact person.

SECTION V — GENERAL INFORMATION

Enter other miscellaneous information regarding the individual provider.

Element 44

Refer to the list on page 4 of the Out-of-State Provider Data Sheet and circle the appropriate provider type and specialty that accurately describes the type of services performed by the applicant. The provider is required to submit the materials specific to the provider type selected with the completed Out-of-State Provider Data Sheet.

Element 45 — Medicare Enrollment Information

This is a situational field. Check all applicable types of Medicare enrollment that the provider holds and enter the enrollment effective date.

Element 46 — Clinical Laboratory Improvement Amendment Number

This is a situational field. Enter the Clinical Laboratory Improvement Amendment (CLIA) number for the provider.

Elements 47a-d — Drug Enforcement Agency (DEA) Information

These are situational fields. Enter the DEA number(s) for the provider. Additional space is provided to allow for multiple DEA numbers.

Element 48 — Individual or Organization License and State of License

This is a situational field. Enter the provider's license number and the state through which the provider's license was received.

SECTION VI — TAXONOMY CODE

Indicate the provider's primary taxonomy code. This should be the taxonomy code the provider intends to use when conducting business with Wisconsin Medicaid.

Element 49 — Primary Taxonomy Code

Enter the provider's primary taxonomy code.

SECTION VII — SUBPART NATIONAL PROVIDER IDENTIFIER (NPI) (For Hospital Providers Only)

Hospital providers may have identified subparts for their organization and obtained an NPI for those subparts (e.g., psychiatric unit, rehabilitation unit). Indicate the hospital provider's subpart NPI(s) the provider intends to use when conducting business with Wisconsin Medicaid.

Elements 50-52a-b — Subpart NPIs and Associated Taxonomy Codes

Indicate the hospital provider's subpart NPI(s) and associated taxonomy codes.

SECTION VIII — AUTHORIZED SIGNATURE INFORMATION

Element 53 — Signature — Provider

The signature of the individual provider or authorized representative of a clinic or facility provider is required. Signature stamps and electronic signatures are not acceptable.

Element 54 — Date Signed

Enter the month, day, and year (in MM/DD/CCYY format) this form was completed and signed.