

**WISCONSIN MEDICAID
IN-STATE EMERGENCY PROVIDER DATA SHEET**

Instructions: Type or print clearly. Before completing this form, read In-State Emergency Provider Data Sheet Completion Instructions, F-11002A. This is required in order to submit claims for emergency services. Submit the completed form with any applicable attachments to ForwardHealth, In-State Emergency Claims, 6406 Bridge Road, Madison, WI 53784-0011.

SECTION I — PRACTICE LOCATION INFORMATION

| | | | |
|--|---------------------------|-------------------|---------------------------------------|
| 1. Name — Provider | | 2. Provider ID | |
| 3. Address Line 1 | | 4. Address Line 2 | |
| 5. City | 6. State | 7. ZIP+4 Code | |
| 8. County | | | |
| 9. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | 10. Name — Contact Person | | 11. Telephone Number — Contact Person |

SECTION II — PROVIDER FINANCIAL INFORMATION

Taxpayer Information

| | | | |
|---|------------------------|---------------------|--|
| 12. Taxpayer Identification Number (TIN) | | 13. Name — Taxpayer | |
| 14. TIN Type <input type="checkbox"/> EIN <input type="checkbox"/> SSN | 15. TIN Effective Date | 16. TIN End Date | |

Checks and Remittance Advice Information

| | | | |
|-------------------------------------|-----------|---|--|
| 17. Address Line 1 | | 18. Address Line 2 | |
| 19. City | 20. State | 21. ZIP+4 Code | |
| 22. Name — Financial Contact Person | | 23. Telephone Number — Financial Contact Person | |

IRS Form 1099 Mailing Address

| | | | |
|--------------------|-----------|--------------------|--|
| 24. Address Line 1 | | 25. Address Line 2 | |
| 26. City | 27. State | 28. ZIP+4 Code | |

Continued

SECTION III — MAILING INFORMATION

| | | | |
|--------------------|-----------|---------------------------|--|
| 29. Name — Mail To | | 30. Name — Attention Line | |
| 31. Address Line 1 | | 32. Address Line 2 | |
| 33. City | 34. State | 35. ZIP+4 Code | |

SECTION IV — GENERAL INFORMATION

36. Refer to page 3 of this form and choose the applicant's appropriate provider type and specialty.

37. Medicare Enrollment Information

Check all applicable types of enrollment.

Part A Effective Date _____

Part B Effective Date _____

38. Clinical Laboratory Improvement Amendment (CLIA) Number

| | |
|--|--------------------|
| 39a. Drug Enforcement Agency (DEA) Number(s) | 39b. DEA Number(s) |
| 39c. DEA Number(s) | 39d. DEA Number(s) |

40. Individual or Organization License and State of License

SECTION V — TAXONOMY CODE

41. Primary Taxonomy Code

SECTION VI — AUTHORIZED SIGNATURE INFORMATION

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.

| | |
|--|----------------------------|
| 42. SIGNATURE — Provider or Authorized Agent (Required) | 43. Date Signed (Required) |
|--|----------------------------|

Continued

Key
 Attach the required copies, as indicated, to the data sheet:
 A = Copy of license covering date of service.
 B = Copy of Medicare enrollment approval.
 C = Copy of approvals/certifications from appropriate associations and organizations (e.g., American Speech-Language Hearing Association).
 D = Copy of approval by the Joint Commission (Formerly the Joint Commission on Accreditation of Healthcare Organizations).

Circle the number that indicates the applicant's provider type and specialty as instructed in Element 36. Complete "Other" if the applicable provider type and specialty are not listed.

| Types / Specialties | Materials to Be Submitted with Data Sheet |
|---|--|
| 26. Ambulance, Land or Air | A |
| 02. Ambulatory Surgery Center..... | B |
| 32. Anesthesiologist Assistant / Certified Registered Nurse Anesthetist (Not an M.D.) | A |
| 20. Audiologist | C |
| 15. Chiropractor | A |
| 30. End-Stage Renal Disease Service..... | B |
| 22. Hearing Instrument Specialist | A |
| 05. Home Health Agency | B |
| 05 / 053. Home Health Agency (With Personal Care)..... | B |
| 06. Hospice..... | B |
| 01. Hospital..... | A & B or D |
| 53. Individual Medical Supply, List specialty. _____ (e.g., Individual Orthotist, Individual Prosthetist) | C |
| 58. Institutes for Mental Disease..... | A |
| 28 / 280. Laboratory / Independent Lab..... | B |
| 11 / 112. Licensed Psychologist (With Ph.D.)..... | A |
| 25. Medical Equipment Vendor..... | C |
| 09. Nurse Practitioner | A & C |
| 16. Nurse Services, List specialty. _____ (e.g., Registered Nurse, Licensed Practical Nurse, Respiratory Care, Nurse Midwife, Independent Nurse) | A |
| 03. Nursing Home..... | A |
| 78. Occupational Therapist..... | A |
| 19. Optician..... | C |
| 18. Optometrist | A |
| 05/052. Personal Care Agency | A |
| 24. Pharmacy..... | A |
| 77. Physical Therapist..... | A |
| 31. Physician (M.D.), List specialty. _____ (e.g., General Practice, Psychiatry. If specialty is psychiatry, send proof of completed residency.) | A |
| 14. Podiatrist..... | A |
| 29. Portable X-ray..... | B |
| 04. Rehabilitation Agency | B |
| 74. Speech and Hearing Clinic..... | C |
| 79. Speech-Language Pathologist (Bachelor's or Master's Degree)..... | C |

Other. Explain the applicant's specialty in the space provided and submit the applicable required materials (A-D) or requirements of the state in which certification is maintained.