DEPARTMENT OF HEALTH SERVICES
Office of the Inspector General
F-11022 (10/2016)

STATE OF WISCONSIN
DHS 106.13, Wis. Admin. Code

WISCONSIN MEDICAID
RURAL HEALTH CLINIC STATISTICAL DATA

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

Personally identifiable information about providers or other entities is used for purposes directly related to program 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 payment for services.

The use of this form is mandatory.

Instructions: Type or print clearly.

SECTION 1 – REPORTING PERIOD

Date From	Date To

SECTION 2 – RURAL HEALTH CLINIC (RHC) INFORMATION

Name – RHC	RHC Provider ID / NPI Number	Non-RHC Provider ID(s)

Street Address / PO Box

City	State	ZIP Code

SECTION 3 – CONTACT(S)

Individual who should receive notices of adjustments, settlements and other correspondence

Name	Title
Telephone Number	Fax Number

Individual who can be contacted if information is required concerning details of this cost report

Name	Title
Telephone Number	Fax Number

SECTION IV – MEDICAID-CERTIFIED PROVIDER EMPLOYED OR CONTRACTED BY THE CLINIC

List the name, provider specialty, and rendering provider ID of all providers employed or contracted by the clinic during this reporting period. Include information for all Medicaid-certified providers.

Note: Any new enrollments or changes (terminations or corrections) should be made by contacting Wisconsin Medicaid at the following address:

Wisconsin Medicaid
Provider Maintenance
313 Blettner Blvd
Madison WI 53784

Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID
Name – Provider	Specialty	Individual Provider ID

SECTION V – CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

I hereby certify that I have examined this cost report and accompanying forms for the period noted. To the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the RHC, in accordance with applicable instructions, except as noted.

SIGNATURE – Officer or Administrator of Clinic	Date Signed

RESET FORM