DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-01146 (02/09)

STATE OF WISCONSIN

WISCONSIN CHRONIC DISEASE PROGRAM
PROVIDER DATA SHEET

Wisconsin Chronic Disease Program requires information to enable the chronic disease program to certify providers to pay for medical services provided to eligible recipients.

Personally identifiable information about Program providers is used for purposes directly related to the 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 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 for a Wisconsin Chronic Disease Program participant.

Note: In order to be reimbursed for services provided in the Chronic Renal Program, Wisconsin Chronic Disease Program must receive correct and complete claims, including resubmissions and adjustments, within 730 days from the date the service was rendered. To be reimbursed for services provided in the Adult Cystic Fibrosis Program or Hemophilia Program, correct and complete claims, including resubmissions and adjustments, must be received within 365 days from the date the service was rendered.

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 check the appropriate box for a provider type.

- ❑ Hospital
- ❑ Pharmacy
- ❑ Medical ____ (indicate specialty)
- ❑ Other ____ (indicate specialty)

8. Medicare Number	9. Medicaid Number	10. License 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

On behalf of ____("Provider"),
(Provider's Name is required)

the undersigned as an authorized representative of Provider, hereby agrees to the following conditions of participation for the Wisconsin Chronic Disease Program ("WCDP"):

1. Provider will comply with all applicable provisions of chs. DHS 152, 153, and 154, Wisconsin Administrative Code, and that if it fails to comply with any such provision, the Wisconsin Department of Health Services ("DHS") may terminate the Provider's participation in WCDP.

2. Provider will submit claims for reimbursement through WCDP on forms designated by DHS, and must be signed by an authorized representative of Provider, who certifies to the truthfulness, accuracy and completeness of the information provided in the claim form.

3. Provider will not claim reimbursement through WCDP by means other than submitting paper claims unless Provider is approved by DHS for electronic claims submission, and that if Provider is approved by DHS for electronic claims submission, the signature of the authorized representative below certifies to the truthfulness, accuracy and completeness of all information submitted by Provider through electronic claims submission.

SIGNATURE - Authorized Representative of Provider	Date Signed
SIGNATURE - Department of Health Services	Date Signed

Return To: **WCDP**
P.O. Box 6410
Madison, WI 53716

Provider Copy.
Please keep for your records.