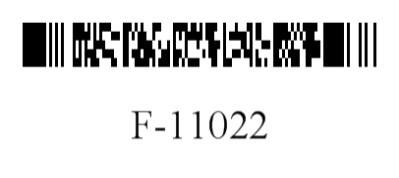
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| --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES**  Office of the Inspector General  F-11022 (10/2016) | | **STATE OF WISCONSIN**  DHS 106.13, Wis. Admin. Code | | |
| wisconsin medicaid rural health clinic statistical data | | | | |
| 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 |
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| 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 |