

**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 — Contact Person

**IRS Form 1099 Mailing Address**

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

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**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 \_\_\_\_\_

DMERC      Effective Date \_\_\_\_\_

**Note:** Wisconsin Medicaid will use the NPI indicated in Section II of this form for processing automatic Medicare crossover claims.

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 — 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.

41. <b>SIGNATURE</b> — Provider or Authorized Agent (Required)	42. Date Signed (Required)
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**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.

<b>Types / Specialties</b>	<b>Materials to Be Submitted with Data Sheet</b>
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
<b>Other.</b> 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.	