 **Name of Provider**:

**Provider Type: (please check all that apply)**

**\*The WWWP Provider shall identify a billing contact person who is available for the Department to contact about billing questions on all State of Wisconsin workdays between 8:30 a.m. and 4:30 p.m. Central Time Zone.**

[ ]  Federally Qualified Health Center (FQHC)

[ ]  Health System

[ ]  Outpatient Hospital Clinic

[ ]  Rural Health Clinic

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| --- | --- | --- | --- | --- |
| **Hospital/Clinic Site** | **Address****(include street, city, state, zip)** | **County** | **Clinical Contact****(name, phone, email)** | **\*Billing and Reimbursement Contact (name, phone, email)** |
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