DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-11001 (07/12)

STATE OF WISCONSIN
DHS 105.03(1) and 105.48, Wis. Admin. Code

WISCONSIN MEDICAID
OUT-OF-STATE PROVIDER DATA SHEET

Instructions: Type or print clearly. Before completing this form, read Out-of-State Provider Data Sheet Completion Instructions, F-11001A. This is required in order to submit claims or prior authorizations for services performed outside Wisconsin. Submit the completed form with attachments to ForwardHealth, Out-of-State Claims, 313 Blettner Blvd, Madison, WI 53784.

Reason for Sending Out-of-State Provider Data Sheet — Check One

❑ Prior Authorization ❑ Claim for Emergency Services ❑ Update to Provider Data

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. Gender ❑ Male ❑ Female	9. Name — Contact Person	10 Telephone Number — Contact Person

SECTION II — PROVIDER FINANCIAL INFORMATION

Taxpayer Information

11. Taxpayer Identification Number (TIN)	12. Name — Taxpayer	
13. TIN Type ❑ EIN ❑ SSN	14. TIN Effective Date	15. TIN End Date

Checks and Remittance Advice Information

16. Address Line 1	17. Address Line 2	
18. City	19. State	20. ZIP+4 Code
21. Name — Financial Contact Person	22. Telephone Number — Financial Contact Person	

IRS Form 1099 Mailing Address

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

Continued

SECTION III — MAILING INFORMATION

28. Name — Mail To		29. Name — Attention Line
30. Address Line 1		31. Address Line 2
32. City	33. State	34. ZIP+4 Code

SECTION IV — PRIOR AUTHORIZATION INFORMATION

35. Name — Provider		36. Name — Attention Line
37. Address Line 1		38. Address Line 2
39. City	40. State	41. ZIP+4 Code
42. Fax Number		43. Telephone Number — Contact Person

SECTION V — GENERAL INFORMATION

44. Refer to page 4 of this form and choose the applicant's appropriate provider type and specialty.

45. Medicare Enrollment Information
Check all applicable types of enrollment.
❑ Part A Effective Date _____
❑ Part B Effective Date _____

46. Clinical Laboratory Improvement Amendment (CLIA) Number

47a. Drug Enforcement Agency (DEA) Number(s)	47b. DEA Number(s)
47c. DEA Number(s)	47d. DEA Number(s)

48. Individual or Organization License and State of License

SECTION VI — TAXONOMY CODE

49. Primary Taxonomy Code

Continued

SECTION VII — SUBPART NATIONAL PROVIDER IDENTIFIER (NPI) (For Hospital Providers Only)	
50a. Subpart NPI	50b. Associated Taxonomy Code
51a. Subpart NPI	51b. Associated Taxonomy Code
52a. Subpart NPI	52b. Associated Taxonomy Code

SECTION VIII — 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.

53. **SIGNATURE** — Provider or Authorized Agent (Required)	54. Date Signed (Required)

Continued

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 44. Complete "Other" if the applicable provider type and specialty are not listed.

Types / Specialties		**Materials to Be Submitted with Data Sheet**
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
27.	Dentist	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

Other. 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.