# Wisconsin Medicaid
# Anesthetist Certification Packet

Wisconsin
Department of
Health and Family Services

Jim Doyle
Governor

Helene Nelson
Secretary

**State of Wisconsin**

Department of Health and Family Services

**DIVISION OF HEALTH CARE FINANCING**

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Dear Medicaid Provider Applicant:

Thank you for applying for certification with the Wisconsin Medicaid program. Once you are a Medicaid provider, you will play a significant part in improving the health of low-income people in your community.

Enclosed are the certification materials you requested. Please review these materials carefully. These materials must be completed and processed before you may become a certified provider for the Wisconsin Medicaid program and begin receiving payments.

Upon certification as a Wisconsin Medicaid provider, you will receive the All Provider Handbook containing general instructions for all providers. In addition, you will also receive publications relating to the specific services you will be providing. These publications will identify the services covered by the Medicaid program and will describe Medicaid billing procedures. After reading those materials, if you have additional questions, we encourage you to use provider services. These services include both telephone and on-site assistance. If you are interested in using these services, please contact the Provider Services Unit addresses and telephone numbers listed in the All Provider Handbook.

We realize that all providers appreciate prompt payments, so we encourage providers with computers to submit claims electronically. This method reduces clerical errors and decreases turn around time. If you are interested in electronic submission of claims and would like more information, including the free software, please contact (608) 221-4746. Information is included in your certification materials regarding electronic submission of claims.

Thank you, again, for your interest in becoming a certified Wisconsin Medicaid provider and for the important services that you will provide to Medicaid recipients. If you have any questions about enclosed materials, please contact the Wisconsin Medicaid Correspondence Unit at (608) 221-9883 or toll-free at 1-800-947-9627.

Sincerely,

Peggy B. Handrich

Peggy B. Handrich
Associate Administrator

PBH:mhy
MA11065.KZ/PERM

Enclosure

# Wisconsin Medicaid
# Checklist for Certification

The items listed below are included in your certification application. Please use this form to check that you received the materials and verify which materials you returned. Please copy all documents for your records before sending them to the fiscal agent. Keep this checklist for your records. Mail your completed application to:

Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

**The required items must be completed and returned to Wisconsin Medicaid:**

| | Item | Required | Optional | Date Sent |
|---|---|---|---|---|
| 1. | Provider Application | X | | |
| 2. | Provider Agreement (2 copies) | X | | |
| 3. | Publications Deletion Form | | X | |
| 4. | Publications Addition Form | | X | |

**These items are included for your information. Do not return them:**

| | Item |
|---|---|
| 1. | General Information |
| 2. | Certification Requirements |
| 3. | Terms of Reimbursement |
| 4. | Electronic Billing Information |

# Wisconsin Medicaid Program
# General Certification Information

Enclosed is the certification application you requested to be a Wisconsin Medicaid provider. Your certification for Wisconsin Medicaid can be approved when you send a **correctly completed application** to the address below and meet all certification requirements for your provider type. **Wisconsin Medicaid cannot reimburse any services you provide prior to your approved certification effective date.** Please carefully read the attached materials.

## Where to Reach Us

If you have questions about the certification process, please call the Wisconsin Medicaid Correspondence Unit for Policy/Billing Information at (608) 221-9883 or toll-free at 1-800-947-9627.

Copy all application documents for your records. Send your completed certification materials to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison, WI 53784-0006

## Certification Effective Date

Wisconsin Medicaid regulations are followed when assigning your initial effective date as described here:

1. The date you notify Wisconsin Medicaid of your intent to provide services is the earliest effective date possible and will be your initial effective date **if**:
   - You meet all applicable licensure, certification, authorization, or other credential requirements as a prerequisite for Medicaid on the date of notification. Do not hold your application for pending licensure, Medicare, or other required certification. Wisconsin Medicaid will keep your original application on file. Send Wisconsin Medicaid proof of eligibility documents immediately once available for continued processing.
   - Wisconsin Medicaid receives your **properly completed certification** application within 30 days of the date the application was mailed to you.

2. If Wisconsin Medicaid receives your application more than 30 days after it was mailed to you, your initial effective date will be the date Wisconsin Medicaid receives your correctly completed application.

3. If Wisconsin Medicaid receives your incomplete or unclear application within the 30-day deadline, you will be granted one 30-day extension. Wisconsin Medicaid must receive your response to Wisconsin Medicaid's request for additional information within 30 days from the date on the letter requesting the missing information or item(s). This extension may allow you additional time to obtain proof of eligibility (such as license verifications, transcripts, other certification, etc.)

4. If you don't send complete information within the original 30-day deadline or 30-day extension, your initial effective date will be based on the date Wisconsin Medicaid receives your complete and accurate application materials.

**Notification of Certification Decision**

Within 60 days after Wisconsin Medicaid receives your completed application, you will be notified of the status of your certification. If Wisconsin Medicaid needs to verify your licensure or credentials, it may take longer. You will be notified as soon as Wisconsin Medicaid completes the verification process.

If you are certified to provide Medicaid services, you will receive written notice of your approval, including your Wisconsin Medicaid provider number and certification effective date.

**Notification of Changes**

Your certification in Wisconsin Medicaid is maintained only if your certification information on file at Wisconsin Medicaid is current. You must inform Wisconsin Medicaid in advance of any changes such as licensure, certification, group affiliation, corporate name, ownership, and physical or payee address. **Send your written notice to Wisconsin Medicaid Provider Maintenance** This notice must state when these changes take effect. Include your provider number(s) and signature. Do not write your notice or change on claims or prior authorization requests.

Failure to notify Wisconsin Medicaid of these types of changes may result in:

- Incorrect reimbursement.
- Misdirected payment.
- Claim denial.
- Suspension of payments in the event provider mail is returned to Wisconsin Medicaid for lack of current address.

**Provider Agreement Form**

Your agreement to provide Medicaid services must be signed by you and the Wisconsin Department of Health and Family Services. This agreement states that both parties agree to abide by Wisconsin Medicaid's rules and regulations.

The agreement is valid for a maximum of one year. All Provider Agreements expire annually on March 31. The Department of Health and Family Services may renew or extend the Provider Agreement at that time.

You cannot transfer, assign, or change the Provider Agreement.

The application includes two copies of the Provider Agreement. Complete, sign, and return both copies. Type or clearly print your name as the applicant's name both on the line on page 1 and on the appropriate line on the last page of the agreement. You must use the same provider name on the application forms and Provider Agreement. When the certification process is complete, you will receive one copy of your processed and signed Provider Agreement. The other copy will be kept in your Wisconsin Medicaid file.

**Terms of Reimbursement (TOR)**

The TOR explains current reimbursement methodologies applicable to your particular provider type. It is referenced by, and incorporated within, the provider agreement. Keep the TOR for your files.

**Certification Requirements**

The Wisconsin Administrative Code contains requirements that providers must meet in order to be certified for Wisconsin Medicaid. The code and any special certification materials applicable to your provider type are included as certification requirements.

**Publications**

Along with your notice, Wisconsin Medicaid will send one copy of all applicable provider publications. The publications include program policies, procedures, and resources you can contact if you have questions.

Many clinics and groups have requested to receive only a few copies of each publication, rather than a personal copy for each Medicaid-certified individual provider in the clinic or group. If you are an individual provider who is a member of a Medicaid-certified clinic or group, you may reassign your copy to your clinic or group office. Please decide if you wish to receive your personal copy of Medicaid publications or if it is sufficient for your Medicaid-certified clinic or group office to receive copies.

If you do not wish to receive personal copies of Medicaid publications, please complete the attached "Deletion from Publications Mailing List Form." If you wish to have your copy of publications reassigned to your clinic or group, also complete the "Additional Publications Request Form."

## ANESTHETIST CERTIFICATION CRITERIA

Per Section HFS 105.055, Wisconsin Administrative Code.

(1) CERTIFIED REGISTERED NURSE ANESTHETIST. For Medicaid certification, a nurse anesthetist shall be licensed as a registered nurse pursuant to s. 441.06. Stat., and shall meet one of the following additional requirements:
   (a) Be certified by either the council on certification of nurse anesthetists or the council on recertifcation of nurse anesthetists; or
   (b) anesthesia program that meets the standards of the council on accreditation of nurse anesthesia educational programs and be awaiting initial certification.Have graduated within the past 18 months from a nurse

(2) ANESTHESIOLOGIST ASSISTANT. For Medicaid certification, an anesthesiologist assistant shall meet the following requirements:
   (a) Have successfully completed a six-year program for anesthesiologist assistant, two years of which consist of specialized academic and clinical training in anesthesia; and
   (b) Work under the direct supervision of an anesthesiologist who is physically present during provision of services.

History: Cr. Register, September 1991, No. 429, effective October 1, 1991.

Provider Type: 43 Effective Date: February 2000

## CLINIC CERTIFICATION CRITERIA

Clinics requesting certification are subject to the certification requirements in Chapter HFS 105, Wisconsin Administrative Code, applicable to the individual providers within the clinic who provide services for which reimbursement is requested from the Wisconsin Medicaid program. The clinic itself can request and be issued a billing number in order to bill for services performed by two or more like providers, i.e., two physicians or two therapists, but not one physician and one therapist. In addition, a clinic number can be issued to one provider when that provider performs services at two separate locations and, therefore, wants to separate the billings and reimbursements according to the location where services were provided.

Billing numbers are assigned to clinics strictly as an accounting convenience to allow payments for services performed by individual clinic members to be made directly to the clinic. The billing number has no independent payment capabilities. In order for reimbursement to be made to the clinic, the billing number must be used in conjunction with the performing provider number of the individual provider who performed the service.

Make sure each individual group member is certified with the Wisconsin Medicaid program prior to performing services. Wisconsin Medicaid cannot reimburse for services provided prior to certification of the performing provider.

| Provider Types: | 19, 20, 27, 28, 29, 30, 31, 32, 33, 34, 35, 37, 38, 43, 45, 78, 84 | Effective Date: | February 1, 1991 |
|---|---|---|---|
| | | Revised: | February 2000 |

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Jim Doyle
Governor

Helene Nelson
Secretary

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

**State of Wisconsin**

Department of Health and Family Services

# ANESTHETIST
# TERMS OF REIMBURSEMENT

The Department will establish maximum allowable fees for all covered anesthesia services provided to Wisconsin Medicaid Program recipients eligible on the date of service. The maximum allowable fees shall be based on various factors, including a review of usual and customary charges submitted to Medicaid, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations. Maximum allowable fees may be adjusted to reflect reimbursement limits or limits on the availability of Federal funding as specified in Federal law.

Providers are required to bill their usual and customary charges for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medicaid patients. For providers using a sliding fee scale for specific services, the usual and customary charge is the median of the individual provider's charge for the service when provided to non-Medicaid patients.

For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum allowable fee established by the Department are determined by the type of procedure performed, the number of 15 minutes time units of anesthesia delivered and whether or not the anesthetist is operating under medical supervision of an anesthesiologist. Medicaid reimbursement, less appropriate copayments and payments by other insurers, will be considered to be payment in full.

The Department will adjust payments made to providers to reflect the amounts of any allowable copayments that the providers are required to collect pursuant to Chapter 49, Wisconsin Statutes.

Payments for deductible and coinsurance payable on an assigned Medicare claim shall be made in accordance with Section 49.46(2)(c), Wisconsin Statutes.

In accordance with Federal regulations contained in 42 CFR 447.205, the Department will provide public notice in advance of the effective date of any significant proposed change in its methods and standards for setting maximum allowable fees for services.

Applicable Provider Type(s): 43

Effective Date: April 1, 1991
Renewed: April 1, 1994
Revised: February 2000

PC08149/TOR

**WISCONSIN MEDICAID**

# PROVIDER APPLICATION INFORMATION AND INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid 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 Medicaid 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:** Type or print your information on this application. Complete all sections. If a question does not apply to your application, write "N/A" in the field. Failure to complete all sections of this application will cause delay and may cause denial of certification.

**IMPORTANT NOTICE:** In receiving this application from and granting Medicaid certification to the individual or other entity named below as "Provider Applicant," Wisconsin Medicaid relies on the truth of all the following statements:

1. Provider Applicant submitted this application or authorized or otherwise caused it to be submitted.
2. All information entered on this application is accurate and complete, and that if any of that information changes after this application is submitted Provider Applicant will timely notify Wisconsin Medicaid of any such change.
3. By submitting this application or causing or authorizing it to be submitted, Provider Applicant agrees to abide by all statutes, rules, and policies governing Wisconsin Medicaid.
4. Provider Applicant knows and understands the certification requirements included in the application materials for the applicable provider types.

If any of the foregoing statements are not true, Wisconsin Medicaid may terminate Provider Applicant's certification or take other action authorized under ch. HFS106, Wis. Admin. Code, or other legal authority governing Wisconsin Medicaid.

**DISTRIBUTION** — Submit completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Road
Madison WI 53784-0006

If you have any questions, call Provider Services at (800) 947-9627.

**FOR OFFICE USE ONLY**

| ECN | Date Requested | Date Mailed |
|---|---|---|
| | | |

| Provider Number | Effective Date |
|---|---|
| Provider Type | Provider Specialty |

## WISCONSIN MEDICAID
# PROVIDER APPLICATION

**INSTRUCTIONS:** Type or print clearly. Before completing this application, read Information and Instructions.

This application is for:

☐ Individual.
☐ Group/Clinic.
☐ Change of Ownership, effective __ __/__ __ /__ __ __ __.

**SECTION I — PROVIDER NAME AND PHYSICAL ADDRESS**

**Special Instructions**
**Name — Provider Applicant** — Enter only one name. All applicants (e.g., individuals, groups, agencies, companies) must enter their name on this line. If your agency uses a "doing business as" (DBA), then enter your DBA name. The name entered on this line must exactly match the provider name used on all other documents for Wisconsin Medicaid.

**Name — Group or Contact Person** — Individual applicants employed by a group or agency should indicate their employer on this line. Applicants who are not employed by a group or agency may use this line as an additional name line or attention line to ensure proper mail delivery.

**Address — Physical Work** — Indicate address where services are primarily provided. Wisconsin Medicaid will send general information and correspondence to this address. Official correspondence will be sent certified. Failure to sign for official correspondence could result in decertification. It is not acceptable to use a drop box or post office box alone. Do not use a Medicaid recipient's residence or a billing service address.

**Date of Birth — Individual / Social Security Number** — Required for individual applicants only. Enter date as MM/DD/YYYY.

**Name — Medicaid Contact Person, Telephone Numbers, and Fax Number** — List the name, telephone number, and fax number of a person within your organization who can be contacted about Medicaid questions. Also list a telephone number clients can use to reach you. This telephone number must be kept current with Wisconsin Medicaid.

**Medicare Part A Number and Medicare Part B Number** — Required for Medicare-certified providers. Please use Medicare numbers appropriate for the same type of services as this application.

| Name — Provider Applicant (Agency Name or Last, First Name, Middle Initial) | | | |
|---|---|---|---|
| Name — Group or Contact Person | | | |
| Address — Physical Work | | | |
| City | State | Zip Code | County |
| Date of Birth — Individual | SSN | | Name — Medicaid Contact Person |
| Telephone Number — Medicaid Contact Person | Telephone Number — For Client Use | | Fax Number |
| Current and/or Previous State Medicaid Provider Number ☐ Wisconsin ☐ Other | | | |
| Medicare Part A Number | | | Effective Date |
| Medicare Part B Number | | | Effective Date |

## SECTION II — ADDITIONAL INFORMATION

**Special Instructions**
Respond to all applicable items:

- **All applicants must complete question 1. Providers with a physical address in Minnesota, Michigan, Iowa, or Illinois** must attach a copy of their current license.
- **Physicians** must answer **question 2**.
- **Applicants who will bill for laboratory tests** must answer **question 3**. Attach a copy of their current Clinical Laboratory Improvement Amendment (CLIA) certificate.
- **All applicants certified to prescribe drugs** must answer **question 4**.
- **Individuals affiliated with a Medicaid-certified group** must answer **question 5**.

1. Individual or Agency License, Certification, or Regulation Number(s)

2. Unique Physician Identification Number (UPIN)

3. CLIA Number

4. Drug Enforcement Administration (DEA) Number

5. Medicaid Clinic/Group Number

## SECTION III — PROVIDER PAYEE NAME AND PAYEE ADDRESS

**Special Instructions**
**Name — Payee** — Enter the name to whom checks are payable. Individuals reporting income to the Internal Revenue Service (IRS) under a SSN must enter the individual name recorded with the IRS for the SSN. Applicants reporting income to the IRS under an employer identification number (EIN) must enter the name exactly as it is recorded with the IRS for the EIN.

**TIN** — Enter the Taxpayer Identification Number (TIN) that should be used to report income to the IRS. Check whether the TIN is an EIN or SSN. The number entered must be the TIN of the payee name entered. The payee name and TIN must exactly match what is on record with the IRS.

**TIN Effective Date** — This is the date the TIN became effective for the provider.

**Name — Group or Contact Person** (Optional) — Enter an additional name (e.g., business, group, agency) that should be printed on checks and Remittance and Status (R/S) Reports (payment/denial report) to ensure proper delivery.

**Address — Payee** — Indicate where checks and R/S Reports should be mailed. A post office box alone may be used for this address.

| Name — Payee | | |
|---|---|---|
| TIN | TIN Effective Date | ☐ EIN or ☐ SSN |
| Name — Group or Contact Person | | |

| Address — Payee | | | |
|---|---|---|---|
| City | County | State | Zip Code |

## SECTION IV — TYPE OF CERTIFICATION

Check the provider type for this application from the list below. A separate application is required (in most cases) for each provider type for which you wish to be certified. An individual may choose only one provider type per application.

- ☐ Ambulance.
- ☐ Ambulatory Surgery Center.
- ☐ Anesthesiology Assistant*.
- ☐ Anesthetist CRNA.
- ☐ Audiologist.
- ☐ Audiologist/Hearing Instrument Specialist.
- ☐ Case Management.
- ☐ Chiropractor.
- ☐ Community Care Organization.
- ☐ Dentist, Specialty _____.
- ☐ End Stage Renal Disease.
- ☐ Family Planning Clinic.
- ☐ HealthCheck Screener.
- ☐ HealthCheck "Other" Services:
  - ☐ Other Eligible Services.
- ☐ Hearing Instrument Specialist.
- ☐ Home Health Agency:
  - ☐ With Personal Care.
  - ☐ With Respiratory Care.
- ☐ Hospice.
- ☐ Independent Lab.
- ☐ Individual Medical Supply:
  - ☐ Orthodontist and/or: Prosthetist.
    Other _____.
- ☐ Medical Vendor/Durable Medical Equipment (DME).
- ☐ Nurse Practitioner:
  - ☐ Certified Nurse Midwife (masters level or equivalent).
- ☐ Nurse Services (Independent Home Care):
  - ☐ Respiratory Care Services.
  - ☐ Private Duty.
  - ☐ Midwife.
- ☐ Occupational Therapy (OT).
- ☐ OT Assistant*.
- ☐ Optician.
- ☐ Optometrist.
- ☐ Osteopath (See below).
- ☐ Osteopath Group/Clinic (See below).
- ☐ Personal Care Agency.
- ☐ Pharmacy.
- ☐ Physical Therapy (PT).
- ☐ PT Assistant*.
- ☐ Physician (See below).
- ☐ Physician Assistant*.
- ☐ Physician Group/Clinic (See below).
- ☐ Podiatrist.
- ☐ Portable X-ray.
- ☐ Prenatal Care Coordination (PNCC).
- ☐ Rehabilitation Agency.
- ☐ Respiratory Therapist.
- ☐ Rural Health Clinic.
- ☐ School-Based Services.
- ☐ Specialized Medical Vehicle Transportation.
- ☐ Speech and Hearing Clinic.
- ☐ Speech and Pathology:
  - ☐ Master's Level.
  - ☐ Bachelor's Level*.
- ☐ Therapy Group (Two therapies, i.e., OT and PT).
- ☐ Others (Describe): _____
  _____.

*Individuals must be supervised and cannot independently bill Wisconsin Medicaid. In most cases, the clinic must submit claims.

**Osteopaths or physicians, or a group/clinic of an osteopath or physician, must indicate the specialty below (select one specialty):**

- ☐ Allergy.
- ☐ Anesthesiology.
- ☐ Cardiovascular Disease.
- ☐ Clinic.
- ☐ Dermatology.
- ☐ Ear, Nose, Throat Otorhinolaryngology.
- ☐ Emergency Medicine.
- ☐ Family Practice.
- ☐ Gastroenterology.
- ☐ General Practice.
- ☐ General Surgery.
- ☐ Geriatrics.
- ☐ Internal Medicine.
- ☐ Manipulative Therapy.
- ☐ Miscellaneous.
- ☐ Nephrology.
- ☐ Neurological Surgery.
- ☐ Neurology.
- ☐ Nuclear Medicine.
- ☐ Obstetrics and Gynecology.
- ☐ Oncology and Hematology.
- ☐ Ophthalmology.
- ☐ Optometry.
- ☐ Orthopedic Surgery.
- ☐ Pathology.
- ☐ Pediatrics.
- ☐ Pediatric Allergy.
- ☐ Pediatric Cardiology.
- ☐ Physical Medicine and Rehab.
- ☐ Plastic Surgery.
- ☐ Preventive Medicine.
- ☐ Proctology.
- ☐ Psychiatry (MDs attach a proof of completed psychiatric residency).
- ☐ Pulmonary Disease.
- ☐ Radiation Therapy.
- ☐ Radiology.
- ☐ Thoracic and Cardiovascular Surgery.
- ☐ Urgent Care.
- ☐ Urology.

## SECTION V — MEMBERS OF GROUP OR CLINIC

Required: If this application is for a group or clinic, complete the chart below by listing all individuals providing Medicaid services at the clinic.

| Name — Provider | Address — Provider Physical Work | Specialty | License Number | Provider Number |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## SECTION VI — APPLICANT'S TYPES OF SERVICE PROVIDED AND TYPE OF BUSINESS

1. List the types of Medicaid services the applicant's agency will provide (such as dental, emergency transportation, home health, personal care, pharmacy, physician, psychiatric counseling, respiratory care services, etc.).

_____

_____

_____

_____

_____

_____

2. Applicant's type of business (check appropriate box):

☐ Individual.

☐ Sole Proprietor:
County and state where registered _____.

☐ Corporation for Nonprofit.

☐ Limited Liability.

☐ Corporation for Profit.
State of registration _____

Names of corporate officers _____

_____

☐ Partnership.
State of registration _____.

Names of all partners and SSNs (use additional sheet if needed):

Name _____ SSN _____

Name _____ SSN _____

Governmental (check one):

☐ County.

☐ State.

☐ Municipality (city, town, village).

☐ Tribal.

☐ Other, specify _____.

**Definitions for Sections VII-IX**

**Controlling interest** — Controlling interest includes, but is not limited to, those enumerated; that is, all owners, creditors, controlling officers, administrators, mortgage holders, employees or stockholders with holdings of 10% or greater of outstanding stock, or holders of any other such position or relationship who may have a bearing on the operation or administration of a medical services-related business.

## SECTION VII — TERMINATION / CONVICTION / SANCTION INFORMATION

Has the applicant, any employee of the applicant, any person in whom the applicant has a controlling interest, or any person having a controlling interest in the applicant been terminated from or convicted of a crime related to a federal or state program?

☐ **Yes** ☐ **No**

If yes, please explain:

## SECTION VIII — CONTROLLING INTEREST IN OTHER HEALTH CARE PROVIDERS

Copy this page and complete as needed.

Does the applicant have a controlling interest in any vendors of special service categories such as, but not limited to, drugs/pharmacy, medical supplies/durable medical equipment, transportation, visiting nurse and/or home health agency, providers of any type of therapy?

☐ **Yes.** Identify each health care provider the applicant has a controlling interest or ownership in, supply the information, and describe the type and percentage of controlling interest or ownership (e.g., 5% owner, 50% partner, administrator).
☐ **No.** Go to Section IX.

| Name | | | |
|---|---|---|---|
| Medical Provider Number(s) | SSN/EIN | | |
| Address | | | |
| City | State | Zip Code | County |
| Telephone Number — Business | Telephone Number — Home | Type and percentage of controlling interest or ownership | |

Are all of the services provided by the applicant and any special service vendors in which the applicant has a controlling interest billed under a single provider number?

☐ **Yes.** Enter the number:_____.
☐ **No.**

## SECTION IX — CONTROLLING INTEREST OTHERS (INDIVIDUAL AND / OR ENTITY) HAVE IN THE APPLICANT

Copy this page and complete as needed.

Does any person and/or entity have a controlling interest in any of the Medicaid services the applicant provides? ☐ **Yes** ☐ **No**

If yes, list the names and addresses of all persons and/or entities with a controlling interest in the applicant.

| Name — Individual or Entity | | | |
|---|---|---|---|
| Address | | | |
| City | State | Zip Code | County |
| Telephone Number — Business | Telephone Number — Home | Type and percentage of controlling interest or ownership | |
| SSN or IRS Tax Number | Provider Number, if applicable | | |

**DEPARTMENT OF HEALTH AND FAMILY SERVICES** **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11015 (12/02)

**WISCONSIN MEDICAID**

# DELETION FROM PUBLICATIONS MAILING LIST

Wisconsin Medicaid requires information to enable Medicaid to certify providers and to authorize and pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to Medicaid 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 Medicaid 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:** Any individual provider who does not wish to receive handbooks, *Wisconsin Medicaid and BadgerCare Updates*, and bulletins under his or her individual provider number must read the following statement, sign it, and date it. Proxy signatures are not acceptable because the individual provider remains responsible for following Wisconsin Medicaid rules and regulations. Requests to discontinue receiving materials will not be processed without individual provider signatures and dates.

---

This authorizes Wisconsin Medicaid not to send me the Wisconsin Medicaid publications (e.g., handbooks, *Updates*, and bulletins) under my provider number as indicated below. This authorization will remain in effect until I am recertified as a Medicaid provider (usually a period of three years), at which time I will have another opportunity to elect whether to receive these publications.

This action will not affect my status as a Wisconsin Medicaid provider.

I am aware that I am personally responsible for compliance with all Wisconsin Medicaid billing and policy requirements specified in any publication, regardless of whether I personally receive or review those publications.

I choose not to receive these publications because:

- Another person or entity acts as my agent in billing and other relations with Wisconsin Medicaid.
- I have access to these publications through another source, such as a clinic in which I render services.

| Name — Provider | Medicaid Provider Number |
|---|---|
| **SIGNATURE** — Provider | Date Signed |

**DISTRIBUTION:** Send completed form to:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

**Wisconsin Medicaid**
**Additional Publications Request Form**

Please attach all individual providers' copies of the "Deletion from Publications Mailing List Form" to this sheet. You must have one of these forms attached for each additional copy of publications you are requesting.

Name of Group or Clinic _____

Group/Clinic Provider Number _____

Address _____

_____

_____

Requested number of additional copies of future publications _____

_____

Authorized Signature Date

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

**State of Wisconsin**

Department of Health and Family Services

DOH 1111A (Rev. 9.97)
DHFS/HEALTH
Wis. Adm. Code HSS 105.01

# DEPARTMENT OF HEALTH AND FAMILY SERVICES
# WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(Standard: for individual and most clinic/group/agency providers)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with **(fill in name here)**

**Provider Name:** _____,
(Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents)
a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program.

4. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:

(a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

(b) the names and addresses of all persons who have a controlling interest in the Provider;

(c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

(d) the names, addresses, and any significant business transactions between the Provider and any subcontractor;

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title 20 services programs since the inception of those programs.

5. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses or similar entitlements as specified in HFS 101 to 108, Wisconsin Administrative Code, and required by federal or state statute, regulation, or rule for the provision of the service.

6. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Wisconsin Medicaid Program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

7. Unless earlier terminated as provided in paragraph 8 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

8. This agreement may be terminated as follows:

(a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

(b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid 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 Medicaid payment for those services."

**SIGNATURES FOLLOW ON PAGE 3**

**ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER.**

_____
Name of Provider (Typed or Printed)

_____
Physical Street Address

_____
City State Zip

TITLE:_____

BY:_____
Signature of Provider

DATE:_____

(For Department Use Only)

STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

**BY:**_____

**DATE:**_____

**MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.**

**PRINT CLEARLY, THIS IS YOUR MAILING LABEL. For recertification (renewals) ONLY.** Fill in the address below **IF** the processed Provider Agreement should be sent to a different address than the physical street address above.

_____
_____
_____
_____

DIVISION OF HEALTH CARE FINANCING

1 WEST WILSON STREET
P O BOX 309
MADISON WI 53701-0309

Telephone: 608-266-8922
FAX: 608-266-1096
TTY: 608-261-7798
www.dhfs.state.wi.us

Jim Doyle
Governor

Helene Nelson
Secretary

**State of Wisconsin**

Department of Health and Family Services

DOH 1111A (Rev. 9.97)
DHFS/HEALTH
Wis. Adm. Code HSS 105.01

# DEPARTMENT OF HEALTH AND FAMILY SERVICES
# WISCONSIN MEDICAID PROGRAM PROVIDER AGREEMENT

(Standard: for individual and most clinic/group/agency providers)

The State of Wisconsin, Department of Health and Family Services, hereinafter referred to as the Department, hereby enters into an agreement with **(fill in name here)**

**Provider Name:** _____,
(Provider's Name and Number (if assigned). Name must exactly match the name used on all other documents)
a provider of health care services, hereinafter referred to as the Provider, to provide services under Wisconsin's Medicaid Program, subject to the following terms and conditions:

1. The Provider shall comply with all federal laws, including laws relating to Title XIX of the Social Security Act, State laws pertinent to Wisconsin's Medicaid Program, official written policy as transmitted to the Provider in the Wisconsin Medicaid Program Handbooks and all other publications, the Civil Rights Act of 1964, the Age Discrimination in Employment Act of 1967, the Age Discrimination Act of 1975, the Department of Health and Family Services Standards for Equal Opportunity in Service Delivery, section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990, and the Wisconsin Fair Employment Law, as are now in effect or as may later be amended.

2. The Department shall reimburse the Provider for services and items properly provided under the program in accordance with the "Terms of Reimbursement," as are now in effect or as may later be amended.

3. In accordance with 42 CFR s. 431.107 of the federal Medicaid regulations, the Provider agrees to keep any records necessary to disclose the extent of services provided to recipients, upon request, and to furnish to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program.

4. The Provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. The Provider shall furnish to the Department in writing:



*Wisconsin.gov*

(a) the names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;

(b) the names and addresses of all persons who have a controlling interest in the Provider;

(c) whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;

(d) the names, addresses, and any significant business transactions between the Provider and any subcontractor;

(e) the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title 20 services programs since the inception of those programs.

5. The Provider hereby affirms that it and each person employed by it for the purpose of providing services holds all licenses or similar entitlements as specified in HFS 101 to 108, Wisconsin Administrative Code, and required by federal or state statute, regulation, or rule for the provision of the service.

6. The Provider consents to the use of statistical sampling and extrapolation as the means to determine the amounts owed by the Provider to the Wisconsin Medicaid Program as a result of an investigation or audit conducted by the Department, the Department of Justice Medicaid Fraud Control Unit, the federal Department of Health and Human Services, the Federal Bureau of Investigation, or an authorized agent of any of these.

7. Unless earlier terminated as provided in paragraph 8 below, this agreement shall remain in full force and effect for a maximum of one year, with the agreement expiring annually on March 31. Renewal shall be governed by s. HFS 105.02(8), Wisconsin Administrative Code.

8. This agreement may be terminated as follows:

(a) By the Provider as provided at s. HFS 106.05, Wisconsin Administrative Code.

(b) By the Department upon grounds set forth at s. HFS 106.06, Wisconsin Administrative Code.

"The Wisconsin Medicaid program requires information to enable the Medicaid program to certify providers and to authorize pay for medical services provided to eligible recipients.

Personally identifiable information about Medicaid providers is used for purposes directly related to the Medicaid 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 Medicaid payment for those services."

**SIGNATURES FOLLOW ON PAGE 3**

**ALL THREE PAGES OF THIS PROVIDER AGREEMENT MUST BE RETURNED TOGETHER.**

_____
Name of Provider (Typed or Printed)

_____
Physical Street Address

_____
City State Zip

TITLE:_____

BY:_____
Signature of Provider

DATE:_____

(For Department Use Only)

STATE OF WISCONSIN DEPARTMENT OF HEALTH AND FAMILY SERVICES

**BY:**_____

**DATE:**_____

**MODIFICATIONS TO THIS AGREEMENT CANNOT AND WILL NOT BE AGREED TO. THIS AGREEMENT IS NOT TRANSFERABLE OR ASSIGNABLE.**

**PRINT CLEARLY, THIS IS YOUR MAILING LABEL. For recertification (renewals) ONLY.** Fill in the address below **IF** the processed Provider Agreement should be sent to a different address than the physical street address above.

_____
_____
_____
_____

# WISCONSIN MEDICAID
# ELECTRONIC BILLING GENERAL INFORMATION

Wisconsin Medicaid has several electronic billing options available for trading partners to submit electronic claims. HIPAA compliant Software is available at no cost for submitting claims to Wisconsin Medicaid except for retail pharmacy services. For further information, or to order free software refer to: *dhfs.wisconsin.gov/medicaid9/pes/pes.htm* or contact the Provider Services at 1-800-947-9627 or the EDI Department at 608-221-9036.

## ELECTRONIC METHODS FOR SUBMITTING MEDICAID CLAIMS

- Provider Electronic Solutions (PES) – Wisconsin Medicaid HIPAA Compliant Free Software
    - 837 Institutional
    - 837 Professional
    - 837 Dental
    - 997 Functional Acknowledgement
    - 835 Health Care Payment Advice

- Cartridge - Providers with the capability to create their claim information on 3480, 3490 or 3490E cartridge can submit those tapes to Wisconsin Medicaid in the HIPAA compliant formats.

- RAS/Internet – Allows providers to send their data files to Wisconsin Medicaid using a direct RAS connection or Web Browser.

- Third Party Biller – Providers have the option of purchasing a billing system or contracting with a Third Party Biller, to submit their claims.