DEPARTMENT OF HEALTH SERVICES
Division of Long Term Care
(Revised 04/11)

STATE OF WISCONSIN
Bureau of Long-Term Support
42 CFR 431.107

THIRD PARTY ADMINISTRATION (TPA)
CHILDREN'S MEDICAID WAIVERS PROVIDER BILLING AND SERVICE INFORMATION

Completion of this form is voluntary. However, providers must submit all information on this form to each county agency that has agreed to authorize children's Medicaid waivers services, and the agency is responsible for submitting this information to the Department of Health Services (DHS), Bureau of Long-Term Support (BLTS). Providers must submit their correct taxpayer identification number or social security number, as reported to the federal Internal Revenue Service (IRS). Providers must also complete and submit a signed federal IRS Form W-9 to the agency that is authorizing the children's Medicaid waivers services. Providers must also report any changes (e.g., business name, address, tax ID, etc.) to the authorizing agency. Failure by the provider to complete this information may result in delay or rejection by the Department's third party claims administrator when processing and issuing payments and 1099s for authorized BLTS children's Medicaid waivers service claims.

SECTION 1: WAIVER AGENCY AUTHORIZED PROVIDER STATUS

Check the appropriate box below to indicate if you are filling out this form for the first time, or if you are updating a previous version

☐ First Time Completing Provider Billing & Service Information Form ☐ Updating Provider Billing & Service Information Form

SECTION 2: BILLING PROVIDER INFORMATION

Provider Business Name or Last Name (as shown on your income tax return)	Billing Provider First Name	Billing Provider MI

Billing Business name, if different from name listed above

Billing Provider Address, Line 1 (**May** be a PO Box)	Billing Provider Address Line 2

Billing Provider City	Billing Provider State	Billing Provider Zip Code	Billing Provider Phone Number

Billing Provider NPI (National Provider Identifier), required for providers of medical services

SECTION 3: SERVICING PROVIDER INFORMATION

Servicing Provider Business or Last Name	Servicing Provider First Name	Servicing Provider MI

Servicing Provider Address, Line 1 **Must not** be a PO Box)	Servicing Provider Address, Line 2

Servicing Provider City	Servicing Provider State	Servicing Provider Zip Code	Servicing Provider Phone Number

Servicing Provider NPI (National Provider Identifier), required for providers of medical services

SECTION 4: PROVIDER SPECIALTY INFORMATION

If you are required to be licensed or certified in order to perform services authorized by the county waiver agency, as required by federal or state statute, regulation, or administrative rule, please complete all fields below:

Provider License Number	Provider License State	License Expiration/Renewal Date (mm/dd/ccyy)

If you provide specialty services, indicate your specialties below:

Provider Specialty 1	Provider Specialty 2	Provider Specialty 3

SECTION 5: PROVIDER STATEMENT AND CONTACT INFORMATION

This is to certify that the information listed above is true, accurate, and complete. I understand that payment of any authorized services will be from Federal and State Medicaid funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

Provider Contact Name	Provider Contact Phone Number	Provider Contact E-mail Address

SIGNATURE – Provider Contact	Date Signed (mm/dd/ccyy)	**Note**: When submitting this form by e-mail, typing your name in the *Provider Contact Name* field serves as your legal signature (Ch. 137, Wis. Stats).