PROFESSIONAL STAFF UPDATE NOTIFICATION

DBA Business Name:_____

Corporate Name If Different (as reported to the IRS):_____

Federal Tax I.D./EIN/FEIN/SSN:_____ NPI:_____
(Organizational)

Name:_____

Degree:_____ Title:_____ License Number:_____ License State_____

☐ Joining ☐ Termination Effective Date:_____ Individual NPI:_____

Clinic Practice Location:_____ Appt. Phone Number:_____

Address:_____ City:_____ Zip:_____

Clinic Billing Location:_____ Billing Phone Number:_____

Address:_____ City:_____ Zip:_____

Only complete the portion below if providing ASD services

WI Autism Spectrum Disorder (ASD) Verification:
Is the Outpatient Mental Health Clinic approved by DHS with a signed Medicaid provider agreement to provide autism spectrum disorder services through the Medicaid Home and Community-based Services as granted by the Centers for Medicare & Medicaid Services (Waiver Program)? ☐ Yes ☐ No
If yes, please provide a copy documenting this relationship and latest certification dated:_____

If No, is the above provider a: ☐ Psychiatrist ☐ Psychologist ☐ Social Worker ☐ Board Certified Behavior Analyst ☐ Other: Non-intensive Autism Provider?

SECTION I: Providing Intensive or Intensive & Non-intensive Level Services:

Pyschiatrist/Psychologist/Social Worker/Board Certified Behavior Analyst:
I certify that I have had at least 2,080 hours of practicing psychotherapy including at least 1,500 hours supervised training involving direct one-on-one work with individuals with ASD, and including all the requirements as stated in 3.36 WI adm. code.

_____ _____
Signature of Qualified Provider Date

SECTION II: Providing Non-itensive Level Services Only:

Non Intensive Autism Provider:
I certify that I have a state license as defined in 3.36 WI adm. code and practice within the scope of a current valid license and that I am only providing Non-intensive ASD services and working under the supervision of an outpatient mental health clinic certified under 51.038 statutes.

_____ _____
Signature of Qualified Provider Date

Return Completed Form To:
Provider Relations, Wisconsin Physicians Service Insurance Corporation
P.O. Box 8190 ▪ Madison, WI 53708-8190

Questions? Give us a call!
Local: 608-221-4711 ▪ Non-WI: 866-357-3020 ▪ Fax: 608-221-5085

Disclaimer: Please note that this is not a contract. This information is used solely to better allow WPS to process claims. To become a preferred provider, please call Provider Relations at 608-977-6618.
HIPAA Disclaimer: The information contained in this form is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, he or she is hereby notified that any reading and dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, and return this form to us at the address on this page via the U.S. Postal Service.
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WPS HEALTH INSURANCE