



PROFESSIONAL STAFF UPDATE NOTIFICATION

DBA BUSINESS NAME \_\_\_\_\_

CORPORATE NAME IF DIFFERENT (as reported to the IRS) \_\_\_\_\_

FEDERAL TAX I.D./EIN/FEIN/SSN \_\_\_\_\_ NPI \_\_\_\_\_

(Organi \_\_\_\_\_ zational)

Name \_\_\_\_\_

Degree \_\_\_\_\_ Title \_\_\_\_\_ License Number \_\_\_\_\_ State \_\_\_\_\_

Effective Date of Joining/Termination (circle one) \_\_\_\_\_ Individual NPI \_\_\_\_\_

Clinic Practice Location \_\_\_\_\_ Appt. Phone# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Clinic Billing Location \_\_\_\_\_ Billing Phone# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

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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, or Psychologist, or Social Worker, or Board Certified Behavior Analyst or Other: Non-Intensive Autism Provider? [circle one and then proceed below to the appropriate listed section]

Section I: Providing Intensive or Intensive & Non-Intensive Level Services:

Psychiatrist /Psychologist /Social Worker/Board Certified Behavior Analyst:

I certify that I have had at least 2080 hours of practicing psychotherapy including at least 1500 hours supervised training involving direct 1:1 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-Intensive 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 s.51.038 Statutes.

Signature of Qualified Provider \_\_\_\_\_ Date \_\_\_\_\_

Return Completed Form To:

Provider Development, HIRSP
P.O. Box 8190
Madison, WI 53708-8190
Local: (608) 221-4711

Non-WI: 1-866-357-3020

Fax: (608) 224-2079

Disclaimer: Please note that this is not a contract. This information is used solely to better allow HIRSP to process claims. 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. Prohibition on Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of a first offense and not more than \$5000 in the case of each subsequent offense.