DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01182 (07/2012)

STATE OF WISCONSIN
DHS 105.02(1), Wis. Admin. Code

WISCONSIN MEDICAID
DECLARATION OF SUPERVISION FOR NONBILLING PROVIDERS

Wisconsin Medicaid requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Personally identifiable information about providers and other entities is used for purposes directly related to 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 payment for those services.

The use of this form is mandatory.

INSTRUCTIONS
Nonbilling providers receive nonbilling provider numbers. The numbers cannot be used independently to bill Wisconsin Medicaid. The following nonbilling providers are required to complete the Provider Change of Address or Status form, F-01181, for changes in physical address and all supervisor changes:

- Occupational Therapy Assistants.
- Physical Therapist Assistants.
- Physician Assistants.
- Speech Therapists, Bachelor of Arts (BA) level.

The nonbilling provider(s) who has changed his or her work address or supervisor should complete Section I. The nonbilling provider's supervisor should complete Section II.

Return the completed form to Wisconsin Medicaid, Provider Maintenance, 313 Blettner Boulevard, Madison, WI 53784. For more information, contact Provider Services at 800-947-9627.

SECTION I — NONBILLING PROVIDER INFORMATION

Name and Credentials — Nonbilling Provider	Provider ID
Address — Nonbilling Provider	Telephone Number — Nonbilling Provider
SIGNATURE — Nonbilling Provider	Date Signed

SECTION II — SUPERVISOR INFORMATION

Name — Supervisor

Street Address Line 1	Street Address Line 2	
City	State	ZIP+4 Code
Telephone Number — Supervisor	Supervisor's Effective Starting Date	

❑ I affirm that _____ is supervising my work as a nonbiller with Wisconsin
(Name of Supervisor Above)

Medicaid effective _____. If _____ discontinues
(Date Listed Above) (Name of Supervisor Above)

Supervision with me, I understand that I must update this information with Wisconsin Medicaid.

Reset Form