



AUTISM SPECTRUM DISORDER (ASD) REQUEST TO PROVIDE SERVICES

Name _____ Degree _____

Psychiatrist Behavioral Analyst Occupational Therapist
 Psychologist Social Worker Speech-Language Pathologist
 _____ Counselor

NPI# _____ Effective Date _____ License # _____

Primary Practice Location _____

Address _____

City, State, Zip _____

Location Tax ID _____

WI Autism Spectrum Disorder (ASD) Verification: Is the Outpatient Mental Health Clinic approved by the Wisconsin Department of Health Services, with a signed Medicaid provider agreement to provide ASD services through the Medicaid Home and Community-Based Services as granted by the Centers for Medicare & Medicaid Services (Waiver Program)?

YES Certification date _____ **Please provide a copy of official documentation of this relationship.**

WI Autism Spectrum Disorder (ASD) Qualifications: Please select your appropriate service provision level as defined on the *Arise Health Plan Criteria for Autism Spectrum Disorders*:

Qualified Intensive Level Professional Qualified Non-Intensive Level Paraprofessional
 Qualified Intensive Level Provider Qualified Non-Intensive Level Professional
 Qualified Intensive Level Supervising Provider Qualified Non-Intensive Level Provider
 _____ Qualified Non-Intensive Level Therapist

I certify that I meet the requirements for the level of service selected, as stated in 3.36 WI Admin. Code and outlined in the Arise Health Plan Criteria.

Signature

Date

Return completed form to:

Network Management, Arise Health Plan, PO Box 11625, Green Bay, WI 54307-1625 Fax: (920) 490-6923

Please note: This is not a contract. This information is used solely to better allow Arise Health Plan to process claims. To become a preferred provider please contact Chris Fredericks at (920) 617-6305.

Ref: Arise Health Plan Criteria for Autism Spectrum Disorders, WI Admin.Code 3.36