Autism Attestation Notification Form

Return completed form to: Aspirus Health Plan, Attn: Provider Relations, PO Box 1890, Southampton, PA 18966 or Fax to 763.847.4010.

PROVIDER INFORMATION

Provider Name	Title	Degree	NPI

License State	License Number	Federal Tax ID/EIN/FEIN/SSN

Clinic Name	Clinic Phone Number	NPI

Clinic Address	City	State	Zip Code

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 documentation of this relationship and latest certification date: _____

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 AND NON-INTENSIVE LEVEL SERVICES

Psychiatrist/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-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 51.038 statutes.

Signature of Qualified Provider	Date

Disclaimer: Please note that this is not a contract. This information is used solely to better allow Aspirus Health Plan to process claims.

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