iLIFE IRIS Vendor Claim Form

Use this form for IRIS-funded, non-HIPAA claims only.

Invoice Number: ________________________________ Invoice Date: _______________________

Medicaid ID:	DOB: ____/____/____	Participant First Name:	Middle:	Participant Last Name:

To be completed by provider:

Billing Provider Dates: Billing Start Date: _____/_____/_______ Billing End Date: _____/_____/________	Provider Name: ________________________________ ________________________________	Provider ID:
Provider Address (street): ________________________________ ________________________________	Provider Address (city, state, ZIP): ________________________________ ________________________________	Provider Contact Person: ________________________________ Phone: ________________________

Service Code	Modifiers	Service From Date MM-DD-YYYY	Service To Date MM-DD-YYYY	Description	POS	Unit Type (each, mile, HR)	Rate	Units	Billed Amount
	Grouped by month.				Paid V9				
	Grouped by pay period.				Paid V7				
					Paid V8				
					Paid V9				
								TOTAL	$

Service dates may be grouped by month or by pay period. Invoices submitted before the due date will be processed and paid on the next pay date. If you prefer to be paid more frequently, submit your invoices on a bi-weekly basis per the Vendor Schedule.

Each service line may only include dates from one calendar month. If your service dates span multiple months, use separate service lines. Submit claims only after services have been rendered.

SAMPLE

Provider Signature: ____

Signature confirms compliance with the IRIS Medicaid Program Provider Agreement found at https://iLIFE.org/wp-content/uploads/f-00180c.pdf.

Participant Signature: ____ Date: _______/_______/________

Please submit the completed form to https://ecm.mcfi.net/Forms/vendorclaims or IRIS.Claims@iLIFE.org or fax to 1-414-918-8213. For details on completing this form, see the IRIS Vendor Claim Form Instructions found at https://iLIFE.org/forms/iris-forms/.