

Invoice Number: _____ Invoice Date: _____

Medicaid ID:	DOB: _____/_____/_____	Participant First Name:	Middle:	Participant Last Name:
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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
TOTAL									\$ _____

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 email 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/>.