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
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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/.