iLIFE
Choice. With Confidence.

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

IRIS Vendor Claim Form

Invoice Number: _____ Invoice Date: _____

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

To be completed by provider: **Please include at least one of the following IDs**

Billing Provider Dates: Billing Start Date: _____/_____/_____ Billing End Date: _____/_____/_____	Provider Name: _____ _____	*Provider ID:_____ **Vendor ID:_____ ***Medicaid ID:_____
Provider Address (Street): _____ _____	Provider Address (City, State, ZIP): _____ _____	Provider Contact Person: _____ Phone: _____

***Provider ID** - SSN or EIN ID number • ** **Vendor ID** - iLIFE assigned ID number • ***Medicaid ID** - ForwardHealth assigned ID number

Service Code	Modifiers	Service From Date MM-DD-YYYY	Service To Date MM-DD-YYYY	Description	Unit Type (each, mile, HR)	Rate	Units	Billed Amount
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							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/.**

(3/2026)