iLIFE
Choice. With Confidence.

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

IRIS Vendor Claim Form

Invoice Number: 12345 Invoice Date: 4/3/2016

Participant Medicaid ID:	DOB:	Participant First Name:	Middle:	Participant Last Name:
1234567890	01 / 01 / 197(	John		Doe

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

Billing Provider Dates:	Provider Name:	*Provider ID: 12-3456789
Billing Start Date: 3 / 1 / 2016	ABC Corp.	**Vendor ID: 09876543
Billing End Date: 3 / 31 / 2016		***Medicaid ID: 11223344
Provider Address (Street): 123 W Street	Provider Address (City, State, ZIP): City, State, 54321	Provider Contact Person: Jane Doe
		Phone: 123-456-7890

***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
S8990	Grouped by month.	3/1/2016	3/31/2016	Physical Therapy	Day	$65.00	10	$650.00
S8990		3/1/2016	3/12/2026	Physical Therapy	Day	$65.00	2.00	$130.00
S8990	Grouped by pay period.	3/13/2016	3/26/2016	Physical Therapy	Day	$65.00	2.00	$130.00
S8990		3/27/2016	3/31/2026	Physical Therapy	Day	$65.00	6.00	$390.00

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 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.

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	| | |							
							Total $	$650.00

Provider Signature: *John Doe*

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

Participant Signature: *Jane Doe* Date: 3/31/2016

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)