

Invoice Number: _____

Invoice Date: _____

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

Medicaid ID:	DOB:	Participant First Name:	Middle:	Participant Last Name:	Pre-authorization Number: NA
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To be completed by provider:

Billing Period Dates Billing Start Date: _____ Billing End Date: _____	Provider Name: Milwaukee County Transit Services	Provider ID (see instructions on reverse): 391220828/3104	
Provider Address (street): _____ _____	Provider Address (city, state, zip): 1942 N. 17th Street Milwaukee, WI 53205	Provider Contact Person: _____ Phone: _____	Participant Discharge Status: NA

If different from the service or rendering provider above:

Billing Provider Name: _____	Billing Provider Address (street / city, state, zip): _____ _____	Billing Provider ID: _____ Phone: _____	Admittance Start Care Date: NA
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Procedure/ Revenue Code	Modifiers	Service From Date MM-DD-YYYY	Service To Date MM-DD-YYYY	Description	POS	Bill Type	Unit Type Each/Mile/HR	Rate	Units	Billed Amount
T2003	R I 			Reduced Fare Bus Pass-Monthly	99	NA	Pass	\$49.50		\$

TOTAL \$

Participant Signature _____ **Date** ____ / ____ / 20 ____

Provider Signature _____

Signature confirms compliance with the IRIS Medicaid Provider Service Agreement outlined on the back of this form.

TRANSIT ONLY