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 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/.