



Provider Name: \_\_\_\_\_

Invoice Number (optional): \_\_\_\_\_

\_\_\_\_\_

Submission Date: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Bill To: TriZetto-Care Wisconsin  
 PO Box 853924  
 Richardson, TX 75085-3924

\_\_\_\_\_

Provider Phone: \_\_\_\_\_

Provider ID (if known): \_\_\_\_\_

Timeliness of Payments. The Health Plan and MCO (or the TPA) will make payment to the Provider within thirty (30) calendar days of receiving a properly submitted claim.

Tax Identification Number: \_\_\_\_\_

Member ID	Member Last Name	Member First Name

Date of Service	Code	Description	Quantity	Rate	Line Total (quantity X rate)
<b>TOTAL \$</b>					

