



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)
TOTAL \$					