CARE WISCONSIN
*Partnering for Independence since 1976*

Facility Name: ______________________________

______________________________

Facility Address: ______________________________

______________________________

Billing Address: ______________________________

______________________________

Billing Phone: ______________________________

Tax Identification Number: ______________________________

Invoice Date: ______________________

Type of Bill: ______________________

Discharge Status: ______________________

Provider ID: ______________________

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

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.

| Member ID | Member Last Name | Member First Name | Original Admission Date | Diagnosis Code |
|---|---|---|---|---|
| | | | | |

| Units (# of days) | Start Date of Service | End Date of Service | Revenue Code | Description | Rate per Day | Total (Units X Rate) |
|---|---|---|---|---|---|---|
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| | | | | | **INVOICE TOTAL $** | |

Residential Invoice Template