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GENERAL SERVICES CLAIM FORM

*** Indicates Required Field**

Care Wisconsin

Invoice Number (optional):

☐ ***New** ☐ ***Corrected**

MEMBER INFORMATION		PROVIDER INFORMATION	
1. ***Care Wisconsin Member Identification #:**		5. **Provider NPI #:** *(If Applicable)*	
2a. ***Member Last Name:**		6. ***Care Wisconsin Provider ID:**	
2b. ***Member First Name:**		7. ***Provider Tax ID:**	
2c. **Member Middle Initial:**		8. ***Provider Legal Name:**	
3. ***Member Date of Birth:**		9. ***Billing Address:**	
4. **Diagnosis Code:**	R69	10. ***City/State/ZIP Code:**	
		11. ***Service Location Name:**	
		12. ***Service Location Address:**	
		13. ***City/State. ZIP Code:**	

14. ***Date of Service (MM/DD/YY)** (Date Span or Individual Days) From Date	To Date	15. ***Place of Service**	16. ***CPT/ HCPCS Code**	17. **Modifier** *(If Applicable)*	18. **Service Description**	19. **Authorization Number**	20. ***Units Billed**	21. ***($) Rate per Unit**	22. ***($) Total Charges**
							0		0.00
							0		0.00
							0		0.00
							0		0.00
							0		0.00
							0		0.00
							0		0.00

I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)

23. **($) Total Charges** $ 0.00

23. **Authorized Signature:**_____ **Print Name:**_____ **Date:**_____

Phone Number: _____

Claim Reminders:
*One Member per Claim Form
* For corrections to services previously billed refer to claim submission instructions

Claim Status Questions:
Care Wisconsin Provider Help Desk
1-855-878-6699

Please Mail this Claim Form to:
Care Wisconsin
P.O. Box 226897
Dallas, TX 75222-6897

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