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RESIDENTIAL CLAIM FORM
*** Indicates Required Field**

Invoice Number (optional):
***New** ***Corrected**

MEMBER INFORMATION		PROVIDER INFORMATION	
1. ***Care Wisconsin Member Identification #:**		8. **Provider NPI #:** *(If applicable)*	
2a. ***Member Last Name:**		9. ***Care Wisconsin Provider ID:**	
2b. ***Member First Name:**		10. ***Provider TAX ID:**	
2c. **Member Middle Initial:**		11. ***Provider Legal Name:**	
3. ***Member Date of Birth:**		12. ***Billing Address:**	
4. ***Diagnosis Code:**	R69	13. ***City/State/ZIP Code:**	
5. ***Admit Start Date:**		14. ***Service Location Name:**	
6. ***Discharge Status:**		15. ***Service Location Address:**	
7. ***Type of Bill**		16. ***City/State. ZIP Code:**	

17. ***Date of Service (MM/DD/YY)** (Date Span or Individual Days) **From Date**	**To Date**	18. ***Revenue Code**	19. ***HCPCS Code** (If Applicable)	20. **Service Description**	21. **Authorization Number**	22. ***Units (# of Days)**	23. ***Rate per Day**	24. ***Total (Units X Rate)**

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

25. **Invoice Total**

26. **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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