



RESIDENTIAL CLAIM FORM

* Indicates Required Field

Invoice Number (optional):

*New

*Corrected

MEMBER INFORMATION		PROVIDER INFORMATION	
1. *My Choice Wisconsin Member Identification #:		8. Provider NPI #: (If applicable)	
2a. *Member Last Name:		9. *My Choice 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:

My Choice Wisconsin Provider Help Desk
1-855-878-6699

Please Mail this Claim Form to:

My Choice Wisconsin - TriZetto
P.O. Box 226897
Dallas, TX 75222-6897