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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:**	Enter Discharge Status	15. ***Service Location Address:**	
7. ***Type of Bill**	Enter Type of Bill Code	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)**
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00
								$0.00

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

25. **Invoice Total** $0.00

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
PO Box 7000
Columbia, MD 21045-7000

Revision –04/01/2024