Invoice Number: 12345 **Invoice Date:** 03/31/2016 Use this form for IRIS-funded, non-HIPAA claims only.

Medicaid ID:	DOB:	Participant First Name:	Middle:	Participant Last Name:	Pre-authorization Number:
1234567890	01/01/1970	John		Doe	

Billing Period Dates:	Provider Name:	Provider ID (see instructions on reverse):	
Billing Start Date: 03 / 01 / 2016 Billing End Date: 03 / 31 / 2016	ABC Corp.	12-3456789 Phone:	
Provider Address (Street):	**Provider Address (City, State, Zip):**	**Provider Contact Person:**	**Participant Discharge Status:**
123 W. Main Street	Your Town, WI 12345	Jane Doe Phone: (123) 456-7980	

Service dates may be grouped by month or by pay period. Invoices submitted before the due date will be processed and paid on the next pay date. If you prefer to be paid more frequently, submit your invoices on a bi-weekly basis per the Vendor Schedule.

Each service line may only include dates from one calendar month. If your service dates span multiple months, use separate service lines. Submit claims only after services have been rendered.

S8990	Grouped by month.	03/01/2016	03/31/2016	Physical Therapy	Paid	V9.	Day	$65.00	10.00	$650.00
S8990		03/01/2016	03/12/2016	Physical Therapy	Paid	V7.	Day	$65.00	2.00	$130.00
S8990	Grouped by pay period.	03/13/2016	03/26/2016	Physical Therapy	Paid	V8.	Day	$65.00	2.00	$130.00
S8990		03/27/2016	03/31/2016	Physical Therapy	Paid	V9.	Day	$65.00	6.00	$390.00

Provider Signature: John Doe

Signature confirms compliance with the IRIS Medicaid Provider Service Agreement outlined on the back of this form.

TOTAL $ $1300.00

Participant Signature: Jane Doe **Date:** 03/31/2016

SAMPLE