Invoice Number: _____ **Invoice Date:** _____ Use this form for IRIS-funded, non-HIPAA claims only.

Medicaid ID:	DOB:	Participant First Name:	Middle:	Participant Last Name:	Pre-authorization Number:

Billing Period Dates: Billing Start Date: ___ / ____ / _____ Billing End Date: ___ / ____ / _____	Provider Name: _____ _____	Provider ID (see instructions on reverse): _____ Phone: _____	
Provider Address (Street): _____ _____	Provider Address (City, State, Zip): _____ _____	Provider Contact Person: _____ Phone: _____	Participant Discharge Status: _____

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.

Procedure/ Revenue Code	Modifiers	Service From Date MM/DD/YYYY	Service To Date MM/DD/YYYY	Description	POS	Bill Type	Unit Type Each/Mile/HR	Rate	Units	Billed Amount

Provider Signature: _____

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

TOTAL $

Participant Signature: _____ **Date:** _____