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:
					N/A

To be completed by provider:

Billing Period Dates	Provider Name:	Provider ID (see instructions on reverse):	
Billing Start Date:	Milwaukee County Transport Systems	391220828	
Billing End Date:		Phone: 414-937-3223	
Provider Address (street):	Provider Address (city, state, zip):	Provider Contact Person:	Participant Discharge Status
	1942 N. 17th Street		
	Milwaukee, WI 53205	Phone:	N/A

If different from the service or rendering provider above:

Billing Provider Name	Billing Provider Address	Billing Provider ID:	Admittance Start Care Date
		Phone:	N/A

Procedure/ Revenue Code	Modifiers	Service From Date CCYY-MM-DD	Service To Date CCYY-MM-DD	Description	POS	Bill Type	Unit Type Each/Mile/HR	Rate	Units	Billed Amount
T2003	R | I | |			Transit Tickets	99	N/A	Book	$205.50		
	| |									
	| |									
	| |									
	| |									

Participant Signature: ______________________________ Date: ___ ___ /___ ___ / 20 ___ ___ TOTAL $

Provider Signature: ______________________________

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

HIPAA claims such as pharmacy and medical services must use the appropriate HIPAA claims forms such as the CMS-1500, UB-04 or the pharmacy claim form and cannot use this form for any reason.

Provider Agreement

Hereinafter referred to as the provider and referenced on the reverse side of this document, hereby agrees and acknowledges as follows:

1. To provide only the items or services authorized by the IRIS participant as listed on the participant's approved individual Support and Services Plan.
2. To accept the payment issued by the Financial Services Agency after IRIS participant authorization as payment in full for provided goods or services.
3. To make no additional claims or charges for provided goods or services.
4. To refund any overpayment to the IRIS Financial Services Agency that issued the payment.
5. To keep records of the items or services provided.
6. To provide, upon request by the DHS or the IRIS Consultant Agency or IRIS Financial Services Agency information regarding the items or services provided.
7. To comply with all other applicable federal and state laws, regulations and policies relating to providing home and community-based waiver services under Wisconsin's Medicaid program.
8. Medicaid Confidentiality Policies and Procedures: To maintain the confidentiality of all records or other information relating to each participant's status as a waiver participant and items or services the participant receives from the Provider.
9. To respect and comply with the IRIS participant's right to refuse medication and treatment and other rights granted the participant under federal and state law.
10. Medicaid Fraud Prevention Policies and Procedures (including records retention): To keep records necessary to disclose the extent of services provided to waiver participants for a period of seven (7) years (http://dcf.wisconsin.gov/memos/num_memos/2001/2001-07.htm) and to furnish upon request to the Department, the Secretary of the federal Department of Health and Human Services, or the state Medicaid Fraud Control Unit, any information regarding services provided and payments claimed by the Provider for furnishing services under the Wisconsin Medicaid Program.
11. The provider agrees to comply with the disclosure requirements of 42 CFR Part 455, Subpart B, as now in effect or as may be amended. To meet those requirements, among other things the provider shall furnish to the Department in writing:
    a. The names and addresses of all vendors of drugs, medical supplies or transportation, or other providers in which it has a controlling interest or ownership;
    b. The names and addresses of all persons who have a controlling interest in the provider;
    c. Whether any of the persons named in compliance with (a) and (b) above are related to another as spouse, parent, child, or sibling;
    d. The names, addresses, and any significant business transactions between the provider and any subcontractor;
    e. The identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or Title XIX services programs since the inception of those programs.

Instructions

Service period dates from and to dates of service are the first and last day covered by this invoice. Provider ID will be an NPI if you have one otherwise you may use your EIN or SSN. Provider contact is the person that should be contacted with questions in regards to this invoice. If some entity other than you bills for the work then this section must be filled in. The billing provider ID can be an NPI, EIN or SSN. The procedure/revenue code is the national code for the procedure or work performed. The description of what was done should also be supplied; this may or may not be the exact national description. Dates of service to and from should be the same date unless the service spans more than one day, such as rental equipment, which may be billed for several consecutive days. Services by the hour must be invoiced per day. Unit type for the service performed. Rate is the amount per unit. Billed amount is the rate multiplied by the number of units billed.