2022 IRIS Vendor Payment Schedule

Pay Period	Pay Period Start Date Sunday at 12:00 AM	Pay Period End Date Saturday at 11:59 PM	Due Date	Pay Date
V1	12/12/21	12/25/21	**12/31/21**	01/14/22
V2	12/26/21	01/08/22	**01/14/22**	01/28/22
V3	01/09/22	01/22/22	**01/28/22**	02/11/22
V4	01/23/22	02/05/22	**02/11/22**	02/25/22
V5	02/06/22	02/19/22	**02/25/22**	03/11/22
V6	02/20/22	03/05/22	**03/11/22**	03/25/22
V7	03/06/22	03/19/22	**03/25/22**	04/08/22
V8	03/20/22	04/02/22	**04/08/22**	04/22/22
V9	04/03/22	04/16/22	**04/22/22**	05/06/22
V10	04/17/22	04/30/22	**05/06/22**	05/20/22
V11	05/01/22	05/14/22	**05/20/22**	06/03/22
V12	05/15/22	05/28/22	**06/03/22**	06/17/22
V13	05/29/22	06/11/22	**06/17/22**	07/01/22
V14	06/12/22	06/25/22	**07/01/22**	07/15/22
V15	06/26/22	07/09/22	**07/15/22**	07/29/22
V16	07/10/22	07/23/22	**07/29/22**	08/12/22
V17	07/24/22	08/06/22	**08/12/22**	08/26/22
V18	08/07/22	08/20/22	**08/26/22**	09/09/22
V19	08/21/22	09/03/22	**09/09/22**	09/23/22
V20	09/04/22	09/17/22	**09/23/22**	10/07/22
V21	09/18/22	10/01/22	**10/07/22**	10/21/22
V22	10/02/22	10/15/22	**10/21/22**	11/04/22
V23	10/16/22	10/29/22	**11/04/22**	11/18/22
V24	10/30/22	11/12/22	**11/18/22**	12/02/22
V25	11/13/22	11/26/22	**12/02/22**	12/16/22
V26	11/27/22	12/10/22	**12/16/22**	12/30/22

- Each pay period begins on the listed Sunday at 12:00 AM and ends two weeks later on the listed Saturday at 11:59 PM.
- Please make sure invoice is complete and correct before submitting to iLIFE.

Submit Invoices via:

Email: IRIS.Claims@iLIFEfms.com
Fax: 414-937-2034
Mail: iLIFE, P.O. Box 91760, Milwaukee, WI 53209
Glendale Drop Box: 6100 N. Baker Road, Glendale, WI 53209

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:

To be completed by provider:

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

If different from the service or rendering provider above:

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

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
	| | |									
	| | |									
	| | |									
	| | |									
	| | |									

Provider Signature: ____ TOTAL $ __________

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

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

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.

Invoice Number: 12345 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:
1234567890	01 / 01 / 1970	John		Doe	

To be completed by provider:

Billing Period Dates	Provider Name:	Provider ID (see instructions on reverse):	
Billing Start Date: 3 / 1 / 2016 Billing End Date: 3 / 31 / 2016	ABC Corp.	12-3456789 Phone:	
Provider Address (street): 123 W. Street	Provider Address (city, state, zip): City, State 54321	Provider Contact Person: Jane Doe Phone: 123-456-7890	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 CCYY-MM-DD	Service To Date CCYY-MM-DD	Description	POS	Bill Type	Unit Type Each/Mile/HR	Rate	Units	Billed Amount
S8990	Grouped by month.	3/1/2016	3/31/2016	Physical Therapy	Paid V9.		Day	$65.00	10.00	$650.00
S8990	Grouped by pay period.	3/1/2016	3/12/2016	Physical Therapy	Paid V7.		Day	$65.00	2.00	$130.00
S8990		3/13/2016	3/26/2016	Physical Therapy	Paid V8.		Day	$65.00	2.00	$130.00
S8990		3/27/2016	3/31/2016	Physical Therapy	Paid V9.		Day	$65.00	6.00	$390.00

Provider Signature: John Doe

TOTAL $ 650.00

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

Participant Signature: Jane Doe Date: 3 / 31 / 20 16

iLIFE
Choice. With Confidence.

Vendor Claims Tips

Tips for filing vendor claims for IRIS

HOW TO COMPLETE

- Every claim must include:
    - Participant name (First Name & Last Name)
    - Provider Name (the vendor name)
    - Provider Address
    - Service Code (including modifiers)
    - Service Dates (From and To)
    - Description of services
    - Rate
    - Units
- Although all other fields are optional, it is better to include as much information as you can (to prevent payment delays).
- If service dates span across calendar months, put each month on a different service line.

CORRECTING COMMON PROBLEMS

- **Missing required information** – Resubmit your claim with corrections. Missing details will be noted on the pending problem letter.
- **Lack of documentation** – Resubmit your claim with the missing documentation attached. Missing details will be noted on the pending problem letter.
- **Vendor name change** – Submit a new, complete Vendor Start-up Packet.
- **Problems with service authorization** (service code, service dates, rate or unit) – Contact the Participant or the Participant's IRIS Consultant to have the plan updated.

SPECIAL CIRCUMSTANCES

- If your address is the same as the Participant's address and you are submitting a claim for mileage, you must attach a mileage log to your claim.

HOW TO SUBMIT

Because it provides a record of your submission, we recommend that all claims be submitted via email to IRIS.Claims@iLIFEfms.com. Claims may be submitted via:

- **Email:** IRIS.Claims@iLIFEfms.com
- **Fax:** 414-937-2034
- **Mail:** PO Box 91760, Milwaukee, WI 53209

IMPORTANT: If submitting supporting documentation with your claim, only submit copies of your documents. Always keep the originals for your records.

If you need additional direction or assistance, please call iLIFE at 1-888-800-5599.

Need a Form? Go to www.iLIFEfms.com.