

Invoice Number:

Invoice Date:

This form is for IRIS funded non HIPAA claims only

IRIS Participant Medicaid ID #:	Participant First Name: Middle Initial:	Participant Last Name:
---------------------------------	---	------------------------

Billing Period Dates: Billing Start Date: ____/____/____ Billing End Date: ____/____/____	Provider Name: _____ _____	Provider ID # (see instructions on reverse): _____ Telephone: _____ - _____ - _____
---	----------------------------------	---

Provider Address (street) _____ _____	Provider Address (city, state, zip) _____ _____	Provider Contact Person _____ Telephone: ____ - _____ - _____
---	---	---

Billing Provider Name _____ _____	Billing Provider Address _____ _____	Billing Provider ID _____ Telephone: _____ - _____ - _____
---	--	--

Authorization Code	Service From Date MM/DD/CCY	Service To Date MM/DD/CCYY	Description of Provided Good or Service	Unit Type (each, mile, hr,)	Unit Rate	Number of Units	Billed Amount

Total Amount Billed: \$

Participant/Representative Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Provider signature confirms compliance with the Provider Agreement outlined on the back of this form.

## IRIS Medicaid Provider Agreement

The provider 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 and as are listed on the participant's Support and Service Plan.
2. To accept the IRIS Financial Services Agency payment as payment in full and to make no additional claims for the same good or service.
3. To refund any overpayment to the IRIS Financial Services Agency.
4. To keep a record of the goods and services provided.
5. To provide, upon request by the DHS or the IRIS Independent Consultant Agency or IRIS Financial Services Agency information regarding the goods or services provided.
6. To comply with all other applicable federal and state laws, regulations and policies relating to providing IRIS home and community-based waiver services under Wisconsin's Medicaid program.
7. To maintain the confidentiality of all records or other information relating to each IRIS participant
8. To respect and comply with the IRIS participant's right to refuse medication and treatment and also all other participant rights
9. 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 7 years** ([http://dhfs.wisconsin.gov/dhfs\\_info/num\\_memos/2001/2001-07.HTM](http://dhfs.wisconsin.gov/dhfs_info/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..
10. 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.

**Form 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 fill in. The billing provider ID can be an NPI, EIN or SSN. The preauthorization 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. If you need assistance completing this form please contact the IRIS Financial Service Agency at 1-888-800-5599 or (414)937-2175 Fax: (414)937-2037 or email: [IRIS@MCFI.net](mailto:IRIS@MCFI.net)

**Important Note:** HIPAA claims such as pharmacy, medical services and any goods and services not covered by IRIS 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.

