INCLUSA CLAIM FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MEMBER INFORMATION** | | | | | | | | | | | | | |
| 1. **Member Identification #:** | | | 123456789 | | | | | | | 4. **Member Date of Birth:** | 01/01/1900 | | |
| 2. **Member Last Name:** | | | Member | | | | | | | 5. **Member First Name:** | Name | | |
| 3. **Primary Diagnosis Code (Optional):** | | |  | | | | | | | 6. **Patient Account (invoice) #:** |  | | |
| **PROVIDER SERVICING ADDRESS**  *(SERVICING PROVIDER’S BUSINESS ADDRESS )* | | | | | | | | | | **PROVIDER BILLING ADDRESS**  *(PHYSICIAN'S OR SUPPLIER'S BILLING ADDRESS)* | | | |
| 7. **Provider TAX/EIN/SSN:** | | | 999999999 | | | | | | | 11. **Provider Billing NPI #:** |  | | |
| 8. **Business Name:** | | | Provider A | | | | | | | 12. **Billing Provider Name:** | Provider A | | |
| 9. **Business Address:** | | | Address A | | | | | | | 13. **Billing Address:** | Address A | | |
| 10. **City/State/Zip Code:** | | | City, State and Zip A | | | | | | | 14. **City/State/Zip Code:** | City, State and Zip A | | |
|  | | | | | | | | | | | | | |
| 15. **Date of Service (MM/DD/YY)**  (*Date Span or Individual Days)* | | | 16. **Type of Bill** | **Service Code** | | 19. **Modifiers** | | | | 20. **Authorization Number** | 21. **Rendering Provider NPI #** | 22.**Units**  **Billed** | 23. **($) Total Charge** |
| 17. **Revenue Code** | 18. **HCPCS/ CPT** | **1** | **2** | **3** | **4** |
| **From Date** | **To Date** | |
| 11/12/22 | 11/12/22 | |  |  | S0215 | RI | U2 |  |  | 10000999997 |  | 1 | 0.43 |
| 11/12/22 | 11/12/22 | |  |  | S0215 | RI | U4 |  |  | 10000999996 |  | 1 | 0.74 |
|  |  | |  |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  |  |  |  |  |  |
| 26. **Disclaimer Code:** | | I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)  ***Provider A*** Provider A 11/12/2022  25. **Authorized Signature: Print Name: Date:** | | | | | | | | | | | 24. **($) Total Charges:**  1.17 |

# Claim Reminders:

\*One member per claim form

\*One authorization number per claim line

\*Use same service code that is listed on the Inclusa Service Authorization form

# Claim Status Questions:

WPS Family Care Contact Center: 800-223-6016

# Please Mail this Claim Form to:

Family Care

c/o WPS Health Insurance

P.O. Box 211595

Eagan, MN 55121

*or*

**FAX:** 608-327-6332 (Do NOT include coversheet)

*Last updated: 09/2022*