INCLUSA CLAIM FORM

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| **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. **($) Total Charge** |
| 17. **Revenue Code** | 18. **HCPCS/ CPT** | **1** | **2** | **3** | **4** |
| **From Date** | **To Date** |
| 11/12/22 | 11/12/22 |  |  | S0215 | RI | U2 |  |  | 10000999997 |  | 1 | 0.43 |
| 11/12/22 | 11/12/22 |  |  | S0215 | RI | U4 |  |  | 10000999996 |  | 1 | 0.74 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| 26. **Disclaimer Code:** | I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)***Provider A*** Provider A 11/12/202225. **Authorized Signature: Print Name: Date:** | 24. **($) 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*