INCLUSA CLAIM FORM

WPS HEALTH INSURANCE

MEMBER INFORMATION

1. **Member Identification #:**		4. **Member Date of Birth:**	
2. **Member Last Name:**		5. **Member First 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:**		11. **Provider Billing NPI #:**	
8. **Business Name:**		12. **Billing Provider Name:**	
9. **Business Address:**		13. **Billing Address:**	
10. **City/State/Zip Code:**		14. **City/State/Zip Code:**	

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**
From Date	**To Date**		17. **Revenue Code**	18. **HCPCS/ CPT**	**1**	**2**	**3**	**4**				

26. **Disclaimer Code:**

I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)

25. **Authorized Signature:** _____ **Print Name:** _____ **Date:** _____

24. **($) Total Charges:**

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: 04/2021