Premier
Financial Management Services

PROVIDER CLAIM FORM

Invoice #: _____

Provider Name: _____

Participant Legal Name: _____ Date of Birth: _____ /_____ /_____

EIN: _____ Provider Address: _____

_____

Instructions: *Please complete the form below. To prevent delay in payment, please fill out all fields. Please make sure the goods and/or services you are billing are included in the participant's (employer) plan. Please reference the Authorization Letter for the service code and description.*

Date of Service	Description	Sevice Code	Modifiers	Units	Rate	Unit Type	Billed Amount

Claim Submission

Mail:
PO Box 26001
Milwaukee, WI 53226

Walk-In:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
Claims@premier-fms.com

Fax:
1-888-859-6472