Premier
Financial Management Services

PROVIDER CLAIM FORM

Invoice #: [Optional, for provider's reference]

Provider Name: Joan Jones [Name on W-9] DBA ACME Care Company [Optional]

Participant Legal Name: Jane Doe Date of Birth: ____/____/_____

EIN: 123456789 Provider Address: 123 Fake St.

Townville, WI 53000

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
01/31/2023	1-2 Bed AFH(Daily)	00240		1	100	Day	100
02/01/23	1-2 Bed AFH (Daily)	00240		1	100	Day	100
02/01/23	Chore Service (15 minutes)	S5120	UI	.75	20	Hour	15
02/10/23	Transportation Trip (Each)	T2003	RI	4	25	Each	100
2/28/23	Home Modification (Each)	S5165		1	1500	Each	1500
3/1/23	Facility-Based Day Svs 15min	T2021	UB	3.25	40	Hour	130
~~1/1-1/31~~	~~SHC (Daily)~~	~~S5125~~		~~31~~	~~20~~	~~Day~~	~~620~~

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