CARE WISCONSIN

Partnering for Independence since 1976

Provider Name: _____

_____

Provider Address: _____

_____

Provider Phone: _____

Provider ID (if known): _____

Tax Identification Number: _____

Invoice Number (optional): _____

Submission Date: _____

Bill To: TriZetto-Care Wisconsin
PO Box 853924
Richardson, TX 75085-3924

Timeliness of Payments. The Health Plan and MCO (or the TPA) will make payment to the Provider within thirty (30) calendar days of receiving a properly submitted claim.

Member ID	Member Last Name	Member First Name

Date of Service	Code	Description	Quantity	Rate	Line Total (quantity X rate)
				TOTAL $	

Non-Residential Invoice Template