



# CLTS WAIVERS CLAIM FORM

## PARTICIPANT INFORMATION

1. Participant Identification #:		4. Participant Date of Birth:	
2. Participant Last Name:		5. Participant First Name:	
3. Primary Diagnosis Code (Optional):		6. Patient Account (invoice) #:	

PROVIDER BUSINESS ADDRESS	PROVIDER BILLING ADDRESS <small>(PHYSICIAN'S OR SUPPLIER'S BILLING ADDRESS)</small>
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) <small>(Date Span or Individual Days)</small>		16. Type of Bill	Service Code		19. Modifiers				20. Reserved for WPS	21. Rendering Prov. NPI #	22. Units Billed	23. (\$) Total Charge
			17. Revenue Code	18. HCPCS/CPT	1	2	3	4				
From Date	To Date											

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of material fact, may be prosecuted under Federal and State Laws.

25. Authorized Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

24. (\$) Total Charges

**Claim Reminders:**

- \*One Participant Per Claim Form
- \*Use same Service Code and/or modifier(s) as appropriate that are listed on the CLTS Service Authorization form.

**Claim Status Questions:**

WPS CLTS Contact Center  
(877) 298-1258

**Please Mail this Claim Form to:**

Bureau of Children's Services CLTS Waiver  
c/o WPS Health Insurance  
P.O. Box 211597  
Eagan, MN 55121