

CLTS WAIVERS CLAIM FORM

| PARTICIPANT INFORMATION | | | | PROVIDER INFORMATION | | | | |
|---|---------|-------------------|-----------|--|----------------------|------------------|--------------------|---------------------------|
| 1. Participant ID #: | | | | 4. Provider NPI #: | | | | |
| 2. Participant Name: | | | | 5. Provider Telephone or Fax #: | | | | |
| 3. Participant Date of Birth: | | | | 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. Rendering Provider Name: | | | | |
| 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. Service Code | 17. Mod 1 | 18. Mod 2 | 19. Reserved for WPS | 20. Units Billed | 21. (\$) Unit Cost | 22. (\$) Total Units Cost |
| From Date | To Date | | | | | | | |
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| 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. | | | | | | | | 23. (\$) Total Charges: |
| 24. Authorized Signature: _____ | | Print Name: _____ | | Date: _____ | | | | |

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 Waivers Customer Service
(877) 298-1258

Please Mail this Claim Form to:

Bureau of Long-Term Support CLTS Waivers
c/o WPS Insurance Corporation
PO BOX 14517
Madison, WI 53708-0517