FAMILY CARE SERVICES / PARTNERSHIP CLAIM FORM

Mail Claims To:

Independent Care Health Plan
P.O. Box 224255
Dallas, TX 75222-4255
1-877-333-6820

Required fields denoted with an asterisk *

*** Member/Client Name:** **DOB:**

*** Member ID Number:** **Gender:**

Patient Account Number:

*** Billing Provider Name:** *** Tax ID Number:**

*** Billing/Remit Address:** **NPI:**

(NPI required for medical services providers)

*** City, State & Zip:**

***Place of Service:**
(Refer to key)

***Diagnosis Code:**
(Refer to key)

Service Request Number/s (authorization): **Number is located on Authorization Letter**

* HIPAA/ Service Code	Modifier 1	Modifier 2	* Date of Service *From (mm/dd/yyyy)*	* Date of Service *To (mm/dd/yyyy)*	* Rate Per Day/Unit	* # Days/ Units	* Total Billed Amount
					Grand Total		

Signature* Date

FAMILY CARE / PARTNERSHIP SERVICES CLAIM FORM KEY

In order to process your claims accurately and timely, please refer to the information below when completing your claim forms. Incomplete claims may result in a delay in processing. Fields marked with "*" are mandatory for processing.

Field	What To Enter
Member/Client Name *	Name (first, middle initial and last) of iCare client
Member ID Number *	Member's Medicaid Number (located on their ForwardHealth card)
Patient Account Number	Provider's own internal account number for the member
DOB	Client's date of birth (mm/dd/yyyy)
Gender	Male or female
Billing Provider Name *	Name of billing entity
Billing/Remit Address *	Address where payment should be sent
City, State & Zip *	City, state and zip code of billing provider
Tax ID Number *	Federal Tax ID number or social security number under which you bill
NPI (if applicable)	National Provider Identifier (assigned to most licensed medical providers)
Place of Service (choose one)*	11 - Provider's office
	12 - Client's home
	99 - Other
Service Request Number (authorization)	Number which authorizes services; can be located on the authorization letter created by the Care Manager.
Diagnosis Code* Effective 10/1/2015	Diagnosis of member use default to Z02.9 if unknown for **Date of Service 10/1/2015**.
HIPAA/Service Code *	HIPAA code provided by iCare which can be located on the service request summary/ authorization or in your contract. It must be a 5-digit/character code.
Modifier 1 and 2 * (if applicable)	2-digit/character code that provides specific information relating to HIPAA code (if applicable); located on the authorization letter after the HIPAA code.
Date of Service From *	Date of service from; must be in mm/dd/yyyy format.
Date of Service To *	Date of service to; must be in mm/dd/yyyy format.
Rate Per Day/Unit *	Dollar amount/rate per day or unit.
# Days/Units *	Quantity or unit of measure (MUST BE WHOLE UNITS)
Total Billed Amt. *	Billed amount for services on that line
Grand Total *	Total of all service lines
Signature*	The Provider Signature indicates responsibility for the implementation of the MCP as described in the Service