

RESIDENTIAL FACILITY CLAIM FORM



Mail Claims To:

NorthernBridges
 Claims Processing
 PO Box 309
 Thiensville, WI 53092
 (800)508-6967

Date Submitted:

(For informational purposes only)

Required fields denoted with an asterisk *.

* Member/Client Name:

* Type of Bill:

(Refer to Key)

* Member ID Number:

DOB:

Gender:

* Billing Provider Name:

* Tax ID Number:

* Billing/Remit Address:

* City, State & Zip:

NPI (Not required for Residences)

Authorization #:

* Rendering Facility Name:

* Rendering Facility Address:

* City, State & Zip:

* Statement Period From:
(mm/dd/yyyy)

* Statement Period To:
(mm/dd/yyyy)

* Admission Date:
(Date of original admission mm/dd/yyyy)

* Discharge Status:
(Refer to Key)

* HIPAA/ Service Code	* Modifier	* Billing Period From Date	* Billing Period To Date	* Number of Days/Units	* Rate Per Day/Unit	* Total Billed Amount
Grand Total						

(Located on letter authorizing services)

(mm/dd/yyyy)

(mm/dd/yyyy)

Grand Total