FAMILY CARE SERVICES 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:**
*** Member ID Number:**
DOB:
Gender:

*** Billing Provider Name:**
*** Tax ID Number:**
*** Billing/Remit Address:**
NPI:
(NPI required for medical services providers)
*** City, State & Zip:**

*** Rendering Provider** (if different from above)**:**
*** Rendering Provider NPI:**

Place of Service:
(Refer to key)
Authorization #:
(Located on letter authorizing services)

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