COMMUNITY CARE UB04 CLAIM FORM

MEMBER INFORMATION		PROVIDER INFORMATION	
1.) Member Last Name:		11.) Provider Legal Name:	
2.) Member First Name:		12.) Billing Address:	
3.) Member Middle Initial:		13.) City/State/Zip Code:	
4.) Member Date of Birth:		14.) Service Location Name:	
5.) Member Account #:		15.) Service Location Address:	
6.) Diagnosis Code:	R6889	16.) City/State:	
7.) Admit Start Date:		17.) Zip Code:	
8.) Admission Source Code:		18.) CCI Provider ID:	
9.) Discharge Status:		19.) Tax ID:	
10.) Type of Bill: (Enter appropriate code. See Instructions for assistance.)		20.) NPI Number:	

21.) Service From Date	22.) Service To Date	23.) Authorization Number	24.) Revenue Code	25.) HCPCS Code	26.) Modifier	27.) Units	28.) Rate	29.) Total
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								30.) Invoice Total
								$ -

31.) Print Name:		32.) Authorized Signature:	
33.) Date:		34.) Phone Number:	
35.) Email Address:		36.) Original DCN if Corrected Claim:	

I certify that all services indicated above have been provided. (Claims for services must reflect actual services provided.)

Please Mail, Fax or E-Mail this form to:
Community Care, Inc.
Attn: Claims Processing
P.O. Box 923
Brookfield, WI 53008-0923
FAX: (414) 385-6615
EMAIL: ClaimsProcessing@communitycareinc.org

6/2023