COMMUNITY CARE UB04 CLAIM FORM

MEMBER INFORMATION		PROVIDER INFORMATION	
1.) Member Last Name:		10.) Provider Legal Name:	
2.) Member First Name:		11.) Billing Address:	
3.) Member Middle Initial:		12.) City/State/Zip Code:	
4.) Member Date of Birth:		13.) Service Location Name	
5.) Member Account Number:		14.) Service Location Address:	
6.) Diagnosis Code: (Click on the box and place a "X" next to the code that applies)	V60.0 ☐ V60.4 ☐ V60.6 ☐	15a.) City/State:	
7a) Admit Start Date:		15b.) Zip Code:	
7b) Admission Source Code:		16.) Community Care Provider ID:	
8.) Discharge Status:		17.) Provider Tax ID:	
9.) Type of Bill: (Enter the appropriate code. See guidelines for assistance.)		18.) Provider NPI Number:	

19.) Service Dates From Date	To Date	20.) Authorization Number	21.) Revenue Code	22.) HCPCS Code	23.) Modifier	24.) Units	25.) Rate	26.) Total
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								$ -
								27.) Invoice Total
								$ -

Please Mail or Fax this Form to:
COMMUNITY CARE, INC.
Attn: Claims Processing
P. O. Box 923
Brookfield, WI 53008-0923
FAX-(414) 385-6615

28.) Authorized Signature /s/:		29.) Print Name:		30.) Date:	

31.) Email Address:		32.) Phone Number:	

33.) Original DCN Number:	

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