MEDICAL EQUIPMENT / SUPPLIES INVOICE
ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

HFS USE ONLY

ELITE PICA

TYPEWRITER ALIGNMENT
USE CAPITAL LETTERS ONLY

222

ELITE PICA

1. Provider Name | 2. Provider Number | 3. Payee | 4. Billing Date | 5. Provider Reference

6. Provider Street | 7. Provider City | State | Zip

Service 8. Sections

Recipient Name (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H. Kids | Cr. Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practioner Name (First, Last) | Ord. Prac. No. | Order Number | Prior Approval

1

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

2

Repeat | Recipient Name (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H. Kids | Cr. Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practioner Name (First, Last) | Ord. Prac. No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

3

Repeat | Recipient Name (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H. Kids | Cr. Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practioner Name (First, Last) | Ord. Prac. No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

4

Repeat | Recipient Name (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H. Kids | Cr. Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practioner Name (First, Last) | Ord. Prac. No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

5

Repeat | Recipient Name (First, MI, Last) | Recipient Number | Birthdate | Acc./Inj. | H. Kids | Cr. Child | Delete

Diagnosis Description | Prefix | Diag. Code

Ordering Practioner Name (First, Last) | Ord. Prac. No. | Order Number | Prior Approval

Cat. Serv. | Item | Pur./Rent | Quantity | Date of Service | TPL Code | Status | TPL Amount | TPL Date | Provider Charge

9. Uncoded TPL Name

12. Sec. # | 13A. TPL Code | 13B. Status | 13C. TPL Amount | 13D. TPL Date

14. #. Sects. | 15. Total Charge

16. Total Deductions

17. Net Charge

My signature certifies that; all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from the patient or any other third party will be properly credited or paid to the Illinois Department of Healthcare and Family Services; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; I am duly authorized as a representative of the entity to be reimbursed by this claim; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and considerations specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations. Completion mandatory, 305 ILCS 5/1-1 et. seq., penalty non-payment, Form Approved by the Forms Management center.

IL 478-1105
HFS 2210 (R-2-15)

Provider Signature | Date

1A 1B PROOF 1 8810027751

FACE; SCREEN 15%