

# LABORATORY/PORTABLE X-RAY INVOICE

ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

HFS USE ONLY

ELITE

PICA

TYPEWRITER ALIGNMENT  
USE CAPITAL LETTERS ONLY

ELITE

PICA

MMM

1. Provider Name	2. Provider Number	3. Payee	4.	5.	6. Acc/Inj	7. Provider Reference
8. Provider Street	9. Facility & City Where Service Rendered			10. Prior Approval		
11. Provider City	State	Zip	12. Referring Practitioner Name (First, Last)			13. Ref. Prac. No.
14. Recipient Name, (First, MI, Last)	15. Recipient Number	16. Birthdate	17. H. Kids	18. Farm Plan	19.	20.
22. Primary Diagnosis			23. Prefix	24. Diag. Code		
25. Secondary Diagnosis			26. Prefix	27. Diag. Code		

### 28. Service Sections

	Procedure Description	Procedure Code	Delete					
1	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>					
	Date of Service	Cat. Serv.	Place of Serv.	TPL Code	Status	TPL Amount	TPL Date	Provider Charge
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
2	Repeat <input checked="" type="checkbox"/> Procedure Description <input type="text"/>	Procedure Code <input type="text"/>	Delete <input checked="" type="checkbox"/>					
	Date of Service	Cat. Serv.	Place of Serv.	TPL Code	Status	TPL Amount	TPL Date	Provider Charge
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
3	Repeat <input checked="" type="checkbox"/> Procedure Description <input type="text"/>	Procedure Code <input type="text"/>	Delete <input checked="" type="checkbox"/>					
	Date of Service	Cat. Serv.	Place of Serv.	TPL Code	Status	TPL Amount	TPL Date	Provider Charge
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
4	Repeat <input checked="" type="checkbox"/> Procedure Description <input type="text"/>	Procedure Code <input type="text"/>	Delete <input checked="" type="checkbox"/>					
	Date of Service	Cat. Serv.	Place of Serv.	TPL Code	Status	TPL Amount	TPL Date	Provider Charge
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
5	Repeat <input checked="" type="checkbox"/> Procedure Description <input type="text"/>	Procedure Code <input type="text"/>	Delete <input checked="" type="checkbox"/>					
	Date of Service	Cat. Serv.	Place of Serv.	TPL Code	Status	TPL Amount	TPL Date	Provider Charge
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
6	Repeat <input checked="" type="checkbox"/> Procedure Description <input type="text"/>	Procedure Code <input type="text"/>	Delete <input checked="" type="checkbox"/>					
	Date of Service	Cat. Serv.	Place of Serv.	TPL Code	Status	TPL Amount	TPL Date	Provider Charge
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
7	Repeat <input checked="" type="checkbox"/> Procedure Description <input type="text"/>	Procedure Code <input type="text"/>	Delete <input checked="" type="checkbox"/>					
	Date of Service	Cat. Serv.	Place of Serv.	TPL Code	Status	TPL Amount	TPL Date	Provider Charge
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>

29.	30. Sect. #	TPL Code	Status	TPL Amount	TPL Date	Total Charges
	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
	Sect. #	TPL Code	Status	TPL Amount	TPL Date	Total Deductions
	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>
	Sect. #	TPL Code	Status	TPL Amount	TPL Date	Net Charges
	<input type="text"/>	<input type="text"/>	<input type="text"/>	\$ <input type="text"/>	<input type="text"/>	\$ <input type="text"/>

31. # Sects  32. Original DCN  33. Orig. Voucher #

Uncoded TPL Name

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.

HFS 2211 (R-2-15)

Provider Signature  Date

1A

1B

PROOF 1

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