ECM and Community Supports Invoice Claim Form

Important: Complete a separate invoice form for each member who received covered services. To avoid processing delays, please ensure completion of the fields with * on this form.

Options for Submitting:

Mail:
Health Net – Cal AIM Invoice
PO Box 10439, Van Nuys, CA 91410-0439
Fax: (833) 386-1043

Email: Non-Standard_InvoiceSubmission@centene.com
Upload PDF: https://CalAim.portal.conduent.com/

Section 1a: Billing Provider Information		
*National Provider Identifier (NPI):	*Tax Identification Number (TIN):	
*Provider's last/Organization name:		
Provider's first name:		
*Address:		*City:
*State: CA	*ZIP:	*Phone number:

Section 1b: Rendering Provider Information		
National Provider Identifier (NPI):	*Tax Identification Number (TIN):	
*Provider's last/Organization name:		
Provider's first name:		
*Address:		*City:
*State: CA	*ZIP:	*Phone number:

Section 2: Member Information - *Please complete a separate form for each member who received services.*		
*Member Client Identification Number (CIN):	Member Homeless Indicator: Select 1 if homeless	
*Last name:	*First name:	*Date of birth (Mo./Day/Yr.):
*Residential address:		
*City:	*State: CA	*ZIP:
*Insured's or Authorized Person's Signature. I authorize payment of Community Supports services to the undersigned physician or supplier for services described below.		

Section 3: Service & Billing Information										
*Payor Primary ID:					Payor Name:					
*Diagnosis Codes	*A:	*B:	*C:	*D:	*E:	*F:	*G:	*H:	*I:	*J:

Service Options *Service unit

#	*Service start date	*Service end date	*Place of service	Service name	*Procedure	*Modifier(s)	*Diag #	*Count	*Cost	*Charge amount
1			Select Plac	Select Service name	Select Proce	Select Modi	Select			$ 0.00
2			Select Plac	Select Service name	Select Proce	Select Modi	Select			$ 0.00
3			Select Plac	Select Service name	Select Proce	Select Modi	Select			$ 0.00
4			Select Plac	Select Service name	Select Proce	Select Modi	Select			$ 0.00
5			Select Plac	Select Service name	Select Proce	Select Modi	Select			$ 0.00
6			Select Plac	Select Service name	Select Proce	Select Modi	Select			$ 0.00
									Invoice Amount	$ 0.00

Section 4: Administrative Information			
*Invoice Date (Mo./Day/Yr.):	*Invoice #:	Control #:	Attachments: Select Yes/No
Authorization ID #:	Submission Type: Select Submission Type	Original Claim ID:	
*Signature of Physician or Supplier (I certify that the statements on the reverse apply to this bill and are made a part thereof.)			
*Signed:		*Date:	