If faxing, please do not mail **Please PRINT in black ink**

MRCI

Billing Statement – Host Home

Client Name_____ County _____

Host Home Provider Name _____ Phone _____

Service Provided:
☐ Host Home ☐ Other_____

Provider (name as shown on W9) _____

Provider Address _____

☐ Please check if this is a new address

City/State/Zip _____

Month _____ Cost per day $_____

Date Service Provided	Cost	Date Service Provided	Cost

Total Due: _____

_____ _____
Signature of Provider Date

1. Complete one form for each Client.
2. Complete a separate sheet for each month.
3. Fax toll-free using 1-888-800-7336.
4. Email to Claims@MyMRCI.org

Office use only
Authorized by_____
'U' code_____
Excel_____

12/2020