



Abri Health Plan
Provider Request to Submit Claims Electronically

Date: _____
Completed by: _____

Provider Name (person or clinic): _____

Telephone # _____ Fax # _____

Email address: _____

Tax ID: _____

Contact name: _____

Telephone # _____ Fax # _____

Email address: _____

Clearinghouse name: _____

*(Clearinghouse is the company who is contracted to provide electronic data interchange (EDI) for your claims processing. This is **not necessarily** your practice management software.)*

Contact name: _____

Telephone # _____ Fax # _____

Email address: _____

How many **Medicaid** claims do you submit to Abri monthly? _____

Please indicate claim type: Professional / Institutional / Both: _____

Billing Provider NPI Number _____

Billing Provider WI Medicaid Number _____

Rendering Provider NPI Number _____

Rendering Provider WI Medicaid Number _____

If you have any questions, please call Customer Service at (414) 847-1776 or email providerservices@abrihealthplan.com.

Fax the completed form to Abri at (414) 847-1778 attention Provider Services or send via email to providerservices@abrihealthplan.com.