Independent Contractor Billing Form

Client Name: _____

Representative Name (if applicable): _____

Representative/Client Address: _____

City/State/Zip Code: _____

Phone: _____

Instructions

1. Complete one form for each Provider.
2. Complete a separate sheet for each month.
3. Email to Claims@MyMRCI.org **(preferred)** or Fax toll-free using 1-888-800-7336.

Service Provided: ☐ Specialist ☐ Housecleaning ☐ Chore Services

☐ Other_____

Provider (name as shown on W9): _____ Phone: _____

Provider Address: _____

☐ Please check if this is a new address.

City/State/Zip: _____

Month _____ Cost per job $_____

Dates of Service provided	Cost

Dates of Service provided	Cost

Total Amount Owed: _____ Date: _____

Signature of Provider **Signature of Client/Representative**

BOTH PROVIDER AND CLIENT/REPRESENTATIVE MUST SIGN