Indiana Health Coverage Programs

Third-Party Liability (TPL)/Medicare Special Attachment Form

This supplemental form is used to submit other payer information for detail line items on *UB-04*, *CMS-1500*, and dental paper claims. This form must be attached to any paper claim that includes TPL and must be submitted to the appropriate address based on claim type.

1.	Billing Provider NPI	a.	Name	b.
2.	Member ID	a.	Name	b.

3. List other payers in order of responsibility. 1– Primary, 2 – Secondary, 3 – Tertiary

Seq	Health Plan ID	Payer Name and Address	Policy Number	Date Paid
1				
2				
3				

4. Enter prior payment amounts per claim detail.

Detail #	Payer Seq	Deductible PR 1	Coinsurance PR 2	Copayment PR 3	Blood Ded PR 66	Psych Red PR 122	Amount Paid	ARC Required if Amount Paid = 0