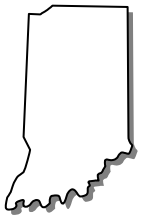
Indiana Health Coverage Programs



CLAIMS ATTACHMENT COVER SHEET

Provider Name _____

Provider Address _____

City, State, ZIP _____

In order to process your attachment(s), this form must be completed as follows:

- Complete a separate form for each claim.
- Write the appropriate attachment control number (ACN) on each attachment.
- Place this form on top of the attachment(s) for each claim.

Attachment Information	
Billing NPI or LPI and Service Location	
Billing ZIP Code+4 (not needed if submitting with LPI)	
Billing Taxonomy Code (not needed if submitted with LPI)	
Dates of Service (from and to dates from the claim)	
RID Number	

ACN	Number of Pages

ACN	Number of Pages