Indiana Health Coverage Programs

INDIANA HEALTH COVERAGE PROGRAMS
PHARMACY CLAIMS ATTACHMENT COVER SHEET

Provider Name

Provider Street Address

City | State | ZIP code

To process the attachment, this form must be completed as follows:

- *Complete a separate form for each claim.*
- *Write the appropriate internal control number (ICN) and the member/recipient (RID) number on each attachment.*
- *Place this form on top of the attachment (8A) for each claim.*

Additional Information (Required)

Billing provider number, nine numeric and one alpha character

Date of Service MM/DD/YYYY

ICN

RID Number

Return via fax to: (317) 488-5163

Mail to: HP Pharmacy Claims
P.O. Box 7268
Indianapolis, IN 46207-7268

Effective: September 2005

Form Number: PRX003