



REQUEST FOR MEDICAID PREGNANCY AND BIRTH EXPENDITURES

Submit requests to: Indiana Medicaid Program
Birth Expenditure Unit
P.O. Box 7262
Indianapolis, IN 46207-7262
Telephone: 1-800-457-4510 or (317) 488-5046
Fax Number: 317-488-5217
E-mail: INXIXTPLRequests@hp.com

- 1. Mother's Name:
2. Mother's Social Security Number:
3. Request Date:

List the following information for all children: (If more than five children, submit another request)

Table with 3 columns: 4. Name, 5. Birth Date, 6. Social Security Number. Includes four rows of blank lines for data entry.

- 7. Requesting Title IV-D Office:
8. Requestor:
9. Telephone Number:
10. Address:
11. City, State, ZIP:

12. Additional Comments:

This electronic transmission contains protected health information (PHI), and is covered by the Electronic Communications Privacy Act, 18 U.S.C. §2510-2521 and the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, which is intended only for the use of the individual or entity named in this fax transmission.