Indiana Health Coverage Programs

MEDICAID THIRD PARTY LIABILITY QUESTIONNAIRE

Date _____ ☐ Insurance ☐ Spenddown

Name _____

Address _____

City, State, Zip Code _____

Medicaid Member Name _____ **Medicaid RID** _____

Social Security Number _____ **Date of Birth** _____

We are requesting your help in updating our files to reflect the correct insurance information on the above-mentioned member.

The Indiana Division of Family and Children, Family and Social Services Administration, is required by federal statute at 41 USC 1396a(a)(25) and federal regulations at 42CFR, 433.138, to identify all group or private insurance for applicants and members of Medical Assistance (Medicaid). Under this federal law and regulation, payment of medical expenses must be pursued against all other resources before Medicaid will authorize payment.

Indiana State law IC 12-25-29-1 requires that you provide our agency with any information you may have that will assist in the identification of medical payment resources. We need any and all group or private insurance information for the above mentioned Medicaid member, even, if the insurance is terminated.

Please complete all fields on the form below and return to the following address, or by facsimile or e-mail:

IHCP Third Party Liability
P.O. Box 7262
Indianapolis, IN 46207-7262

Fax: 1-866-667-6579
E-mail: INXIXTPLRequests@dxc.com
Questions, please call: 1-800-457-4584

Insurance Carrier Name _____ **Benefit Telephone Number** ( )

Insurance Carrier's Complete Address _____

Policyholder's Name/Relationship _____ **Social Security Number** _____

Group Number _____ **Policy Number** _____

Effective Date _____ **Termination Date** _____

Employer Name _____ **Employer Phone Number** ( )

Employer's Complete Address _____

Type of Plan ☐ **Individual** ☐ **Family Plan** **If family plan, list below the covered person(s) complete name and date of birth**

_____

_____

_____

Please **check** the coverage carried by the policyholder and family members under this plan:

☐ Medical ☐ Major Medical ☐ Hospitalization ☐ Pharmacy ☐ Mental Health ☐ Skilled Nursing ☐ Home Health
☐ Intermediate Care ☐ Cancer ☐ Dental ☐ Indemnity ☐ Medicare Supplemental A ☐ Medicare Supplemental B ☐ Other

List Exclusions (if applicable) _____

_____

_____

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