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

When submitting paper claims that require reporting TPL or Medicare information at the detail level, providers must include this form in their submission. Providers should place this special attachment form directly behind the paper claim form. If additional attachments need to be submitted, those attachments should be placed behind this form. Paper claim forms and all relevant attachments should be mailed to the appropriate address based on claim type, as indicated in the *Indiana Health Coverage Programs (IHCP) Quick Reference Guide* at in.gov/medicaid/providers.

For additional help in filling out this form, see the *Quick Reference Guide: TPL/Medicare Special Attachment Form Instructions*.

1a	Billing Provider NPI	Required. Enter the billing provider National Provider Identifier (NPI) (or Provider ID, if atypical). This MUST match the billing provider number submitted on the claim, or the claim and attachment will be returned to the provider. Providers should use the same NPI/Provider ID number submitted in field 56 (*UB-04*), field 49 (*ADA 2006*), or field 33a (*CMS-1500*).
1b	Name	Required. Enter the name of the billing provider.
2a	Member ID	Required. Enter the 12-digit member ID. This number **must** match the member ID submitted on the claim, or the claim and attachment will be returned to the provider. Providers should use the same number as in field 60c (*UB-04*), field 23 or 15 (*ADA 2006*), field 1a (*CMS-1500*).
2b	Member Name	Required. Enter the first and last name of the member.
3.1		USE THIS ROW FOR REPORTING MEDICARE INFORMATION ONLY
3.1	Health Plan ID	Required. This ID should match the health plan ID submitted on the claim form. Sequence number one (3.1) is used for Medicare crossover claims **only**. Other insurance/TPL information should be submitted on sequence two (3.2).
3.1	Payer Name and Address	Enter the Medicare payer name (required) and address.
3.1	Policy Number	Required. Enter the Medicare policy number.
3.1	Date Paid	Required.
3.2		USE THIS ROW FOR REPORTING OTHER INSURANCE TPL INFORMATION
3.2	Health Plan ID	Enter the Health Plan ID, if you have one. Sequence number two (3.2) is used for submitting other insurance/TPL information **only**. Medicare crossover information should be submitted on sequence one (3.1).
3.2	Payer Name and Address	Enter the third-party (commercial insurance) payer name and address.
3.2	Policy Number	Enter the third-party (commercial insurance) policy number.
3.2	Date Paid	Required.
3.3	Health Plan ID	Not currently used for the IHCP. Please leave blank.
3.3	Payer Name and Address	Not currently used for the IHCP. Please leave blank.
3.3	Policy Number	Not currently used for the IHCP. Please leave blank.
3.3	Date Paid	Not currently used for the IHCP. Please leave blank.
4	Detail #	**Required**. Enter 1, 2, 3, and so on, to correspond to the detail number submitted on the accompanying claim. Numbering must be sequential and match detail numbers on the claim. If more than one *IHCP TPL/Medicare Special Attachment Form* is required because of multiple details on the claim, continue to increment the sequence numbers on subsequent pages. Do not restart numbering on each new page.
	Payer Seq	**Required**. Relates to payer identified in section 3. One (1) is always used for Medicare, and two (2) is always used for other insurance (TPL). Payer Seq 3 is not currently used by the IHCP.

	Deductible – PR 1	Required for Medicare crossover claims only.
	Coinsurance – PR 2	Required for Medicare crossover claims only.
	Copayment – PR 3	Required for Medicare crossover claims only.
	Blood Ded – PR 66	Required for Medicare crossover claims only.
	Psych Red – PR 122	Required for Medicare crossover claims only.
	Amount Paid	**Required**. For Payer Seq 1, this amount indicates the Medicare paid amount. For Payer Seq 2, this amount indicates the other insurance/TPL paid amount. Zero is a valid value. This field should contain a dollar amount of 0 or greater.
	ARC	The adjustment reason code (ARC) field is for commercial insurance TPL (Payer Seq 2) only. An ARC code can be entered *IF* the TPL insurer denied payment (so the TPL paid amount is zero) and the denial ARC code on the TPL primary payer explanation of benefits (EOB) is a valid code that can bypass submitting the EOB. Under all other scenarios, this field should be left blank. **Note**: Providers may also submit an EOB instead of providing an ARC code to bypass. An ARC is two to three characters in length and can contain alphabetic characters; however, CO, PR, PI, and OA are ***not*** ARC codes and should not be entered in this field. The list of valid ARC denial codes able to bypass attachment of the TPL EOB can be found in the *Claim Submission and Processing* provider reference module.