Indiana Health Coverage Programs

PROVIDER THIRD-PARTY LIABILITY (TPL) REFERRAL FORM

Indiana Health Coverage Programs (IHCP) providers: *Please complete this form if you have received a request for medical records from an IHCP member's attorney or a record retrieval company on behalf of an attorney relating to a personal injury claim or if you have information about a personal injury claim being pursued by an IHCP member.*

SECTION 1: MEMBER INFORMATION

1. Name of IHCP member
2. Member ID
3. Date of birth
4. Social Security number
5. Member's home address
6. Member's phone number
7. Date of accident or injury
8. Brief description of accident and injuries:

SECTION 2: ATTORNEY/REQUESTING COMPANYINFORMATION

9. Member's attorney's name or name of company requesting records
10. Address
11. Phone number

SECTION 3: INSURER INFORMATION

12. Name of casualty or liability insurance carrier
13. Policy number
14. Claim number
15. Adjuster's name, address and phone number:

Please send this information to the TPL Casualty Department by email at INXIXTPLCasualty@gainwelltechnologies.com, by fax at 866-667-6579, by telephone at 800-457-4584 or by U.S. mail to the following address:

IHCP TPL Casualty Department
P.O. Box 7262
Indianapolis, IN 46207-7762