



AUTHORIZATION / REQUEST FOR PATERNITY BLOOD TEST

State Form 7859 (R5 / 11-06) / CSB 0435

Mail this Form to:
Claims Payment
Family and Social Services Administration
PO Box 28, MS 36
Indianapolis, IN 46206-0028

INSTRUCTIONS: To be completed and signed by Prosecuting Attorney and forwarded, with Child Support Bureau approval for payment, to the provider named below. The provider is to submit this fully completed form and an invoice to the address listed above for payment of this invoice.

County of Prosecuting Attorney	This state agency is requesting disclosure of your Social Security number in order to expedite processing of this form. Disclosure is MANDATORY pursuant to 42 USC 666 (a) (13). Records in this series are CONFIDENTIAL per 42 USC 653, 42 USC 654, and 42 USC 663.
Name of medical services provider	
Street address	
City, state, and ZIP code	
Indiana ISETS case number	

REQUESTED SERVICES	
<input type="checkbox"/> Perform DNA test	<input type="checkbox"/> Draw blood samples
<input type="checkbox"/> Other (specify)	
<input type="checkbox"/> Ship blood samples to: (name)	
Street address	
City, state, and ZIP code	

You are requested to provide the above indicated medical services for the individuals listed below to assist in the determination of paternity for the child named.

INDIVIDUALS FOR WHOM PAYMENT HAS BEEN AUTHORIZED	
Name of child's mother	Social Security number
Name of child	Social Security number
Name of child	Social Security number
Name of putative father	Social Security number
Name of putative father	Social Security number
Comments	

Upon completion of the services requested, you are hereby authorized to submit billing to the Indiana Family and Social Services Administration for payment by the Indiana Department of Child Services, Child Support Bureau, for these services.

CERTIFICATION		
I certify that I am the duly authorized agent of the Indiana Department of Child Services, Child Support Bureau, in IV-D paternity matters in this jurisdiction. I further certify that these services have been requested pursuant to a court order or an agreement between the parties in a IV-D paternity case, and these services are necessary to carry out my obligation pursuant to the terms of a cooperative agreement between this jurisdiction and the Indiana Department of Child Services, Child Support Bureau.		
Signature of authorized agent	Title	Date signed (month, day, year)