CLAIMS ATTACHMENT COVER SHEET

Provider name _____

Provider address _____

City, state, ZIP _____

To process your attachments, this form must be completed as follows:

- Complete a separate form for each claim.
- Write the appropriate attachment control number (ACN) on each attachment.
- Place this form on top of the attachments for each claim.
- Mail forms and attachments to:
  DXC – Claim Attachments
  P. O. Box 7259
  Indianapolis, IN 46207

Attachment Information	
Billing NPI or IHCP Provider ID and service location	
Billing ZIP Code+4 (not needed if submitting with IHCP Provider ID)	
Billing taxonomy code (not needed if submitted with IHCP Provider ID)	
Dates of service (*from* and *to* dates from the claim)	
Member ID or RID	

ACN	**Number of pages**

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