Indiana Health Coverage Programs

MEDICAID THIRD-PARTY LIABILITY QUESTIONNAIRE

Date _____

Provider Name _____

Provider Address _____

City, State, ZIP Code _____

Medicaid Member Name _____ **Member ID** _____

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

This questionnaire is sent to Indiana Health Coverage Programs (IHCP) providers if a third-party payment is reported on a claim, but the IHCP has no record of the member's coverage with that carrier. If this questionnaire is received by mail, please return it within the next **15 days**. This questionnaire is also available on the *Forms* page at in.gov/medicaid/providers for providers to access and submit as needed.

Please complete all fields on this form and submit it via secure correspondence on the IHCP Provider Healthcare Portal, or to the following mailing or email address or fax number:

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

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

Insurance Carrier Name _____ **Benefit Phone 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	☐ Pharmacy	☐ Dental	☐ Optical/Vision
☐ Indemnity	☐ Hospitalization	☐ Cancer	☐ Mental Health	☐ Home Health
☐ Skilled Care in Nursing Facility		☐ Medicare Part A	☐ Medicare Part B	☐ Medicare Part D
☐ Medicare Supplemental Plan		☐ Medicare Advantage Plan		☐ Other

List exclusions (if applicable)