Indiana Health Coverage Programs

PROVIDER TPL REFERRAL FORM

Providers: Please complete if you have received a request for medical records from an IHCP member's attorney relating to a personal injury claim or if you have information about a personal injury claim being pursued by an IHCP member.

1. Name of IHCP Member: _____
2. Member Number: _____
3. Date of Birth: _____
4. Social Security Number: _____
5. Member's Home Address: _____
6. Member's Telephone Number: _____
7. Date of Accident or Injury: _____
8. Brief Description of Accident and Injuries:

_____

_____

_____

9. Member's Attorney Name, Address, and Phone Number:

_____

_____

_____

10. Insurance Information (Name of liability insurance carrier, policy number, claim number, adjuster's name, address, and phone number)

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Please submit this information to the TPL Casualty Unit by e-mail at INXIXCasualty@dxc.com, by fax at 1-866-667-6579, by telephone at 1-800-457-4584, or by U.S. mail to the following address:

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