



C L A I M S A T T A C H M E N T C O V E R S H E E T

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:
Gainwell – Claim Attachments
PO Box 50440
Indianapolis, IN 46250-0440

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 (<i>from</i> and <i>to</i> dates from the claim)	
Member ID or RID	

ACN	Number of pages

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