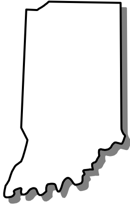

MEDICAID THIRD-PARTY LIABILITY QUESTIONNAIRE

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: 866-667-6579
Email: INXIXTPLRequests@gainwelltechnologies.com
Questions, please call: 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):