Indiana Health Coverage Programs

Third-Party Liability (TPL)/Medicare Special Attachment Form

This supplemental form is used to submit other payer information for detail line items on *UB-04*, *CMS-1500*, and dental paper claims. The information must be provided, in accordance with electronic data interchange (EDI) transaction standards. This form must be attached to any paper claim that includes TPL, including Medicare, and must be submitted to the appropriate address based on claim type.

NOTE: This form is required ONLY if you submit a paper claim form. Electronic claims (837 transactions or Portal transactions) do not require this attachment.

1.	Billing Provider NPI	a.	Name	b.
2.	Member ID	a.	Name	b.

3. List other payers in order of responsibility. 1– Primary, 2 – Secondary, 3 – Tertiary

Health Plan ID	Payer Name and Address	Policy Number	Date Paid	
	Health Plan ID	Health Plan ID Payer Name and Address		

4. Enter prior payment amounts per claim detail.

Detail #	Payer Seq	Deductible PR 1	Coinsurance PR 2	Copayment PR 3	Blood Ded PR 66	Psych Red PR 122	Amount Paid	ARC Required if Amount Paid = 0