

**Division of Medical Assistance
Health Insurance Information Referral Form**

Recipient Name: _____

Recipient ID No: _____ Date of Birth: _____

Health Ins. Co. Name (1) _____ Policy/Cert No. _____

(2) _____ Policy/Cert No. _____

Reason For Referral

- 1. _____ Patient not covered by above policy(s)
- 2. _____ Service not covered by above policy(s)
- 3. _____ Insurance company denied by _____ letter or _____ telephone (please provide name and number of contact person and reason for denial):

- 4. _____ New policy not indicated on Medicaid ID card. Indicate type coverage:
_____ Major Medical _____ Hosp/Surgical _____ Basic Hospital
_____ Dental _____ Cancer _____ Accident
_____ Indemnity _____ Nursing Home
- 5. _____ Insurance company paid patient \$ _____ Date _____ and patient has not paid provider.

If items 1 through 3 are checked, attach original claim and submit to: The Division of Medical Assistance, Third Party Recovery Section, 1985 Umstead Drive, 2508 Mail Service Center, Raleigh, North Carolina 27699-2508. The Third Party Recovery (TPR) Section will verify the information and will either override or reject the claims within 10 working days after receipt.

Item 4 should be used if the patient requests filing with an insurance company that is not indicated on the Medicaid ID card. The TPR Section will enter this information into the TPR database.

Submitted: _____ Provider Number: _____

By: _____ Date Submitted: _____

Telephone Number: _____