PROVIDER RELATIONS

Claim Related Forms

PROVIDER RELATIONS

Claims Related Forms

DHH Medicaid Recipient Insurance Information Update (To update TPL Information)

Special Batching Form (To special batch claims for edit overrides and/or processing)

Patch Code (To place between multiple claims being submitted for processing)

ICN ICN Tracking Form (To request claim ICNs when submitted so claim can be tracked)

OADES TPL Coversheet (Completed for TPL claims that were originally mishandled)

Department of Health and Hospitals
Medicaid Recipient Insurance Information Update
Fax #: 1-866-976-2215

Date of Submission:_____

Provider Name:_____ Phone #:(___)____-_____

Submitter Name:_____ Fax#:(___)____-_____

Recipient Information:	**Policy Information:**
Patient Name: _____	Policy Holder Name:_____
Medicaid ID #:_____	Policy #:_____
Date of Birth: MM/DD/YYYY	Coverage Effective Date: MM/DD/YYYY
Parish of Residence:_____	Carrier Code:_____
Hospital Account #:_____	
Date of Service: MM/DD/YYYY	

Please update the patient's medical file by **ADDING** the following insurance:

Insurance Name:_____

Address: _____

_____

Please update the patient's medical file by **REMOVING** the following insurance:

Insurance Name:_____

Address: _____

_____

PRIVACY AND CONFIDENTIALITY WARNING

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BEGINNING ICN >

ENDING ICN >

SPECIAL BATCHING

ENTER INSTRUCTIONS IN BOXES BELOW

DOCUMENT / CLAIM TYPE _____

SUBMITTED BY _____

DATE _____ NO. OF DOCUMENTS _____

SCREENING / BATCHING

OVERRIDE CODES

SPECIAL INSTRUCTIONS

Patch Code

ICN TRACKING FORM

SUBMITTED BY _____

DEPARTMENT _____

DATE SUBMITTED _____

NUMBER OF CLAIMS _____

PROVIDER TYPE _____

PROVIDER NAME _____

PROVIDER NUMBER _____

PURPOSE _____

BEGINNING ICN _____

ENDING ICN _____

REFERENCE BATCH CONTROL NUMBERS _____

Claim Total

OADES TPL COVERSHEET

	TPL Amt	Deductible	Co Pay	Co Ins	Other	Error 1	Error 2	Error 3	Error 4	Error 5
1										
2										
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