Do not write in this space. Do not use red ink to complete this form.

MEDICAID
OTHER INSURANCE ATTACHMENT

1. Billing Provider ID	a.	Name	b.
2. Medicaid ID	a.	Name	b.

3. List other payors in order of responsibility. Sequence 1=Primary, 2=Secondary, 3=Tertiary

SEQ	a. HEALTH PLAN ID	b. PAYOR NAME AND ADDRESS	c. POLICY NUMBER	d. DATE PAID
1				
2				
3				

4. Indicate TPL payment amounts per claim detail. (Note: For header amount on Institutional claims use detail number 0.)

a. DTL	b. PAYOR SEQ	c. COPAY	d. COINSURANCE	e. DEDUCTIBLE	f. TPL PAID

Submit completed claim to:

HP
Post Office Box 244032
Montgomery, AL 36124-4032