The instructions below show what information should be filled in to specific blanks on the MDwise Healthy Indiana Plan Health Claim Forms.

For complete instructions, please visit www.MDwise.org, choose HIP, Provider Relations, Claims. The full instructions are on the Claims page in PDF format for download.

If you have any questions, please call 1-800-356-1204.
Patient's Name: (Last Name, First Name, Middle Initial)

Patient Relationship to Insured:
- Self
- Spouse
- Child
- Other

Patient Status:
- Single
- Married
- Other

Employed:
- Full-Time
- Part-Time
- Student

Other Insured's Name: (Last Name, First Name, Middle Initial)

Other Insured's Policy Group or FECAP Number:

Is Patient's Condition Related To:
- Employment
- Auto Accident
- Other Accident

Insurance Plan Name or Program Name:

Reserved for Local Use:

Read Back of Form Before Completing & Signing This Form:

Date of Current Illness (First Symptoms or Injury/Accident or Pregnancy): MM DD YY

Name of Referring Provider or Other Source:

Reserved for Local Use:

Diagnosis or Nature of Illness or Injury:

Date(s) of Service:

Place of Service:
- ER

Procedure, Services, or Supplies (Explain Unusual Circumstances): CPT/HCPCS Modifier

Diagnosis Pointer:

F. Charges:

G. Diagnoses:

H. Professional Fee:

I. Id. Okal:

J.Rendering Provider Id.:

Billing Provider Info & Ph #:

Forwarded to: [Signature]

Date:

Medicaid Reimbursement Code:

Original Ref. No.:

Billing Authority Number:

Federal Tax I.D. Number:

Patient's Account No.:

Accept Assignment:
- Yes
- No

Total Charge:

Amount Paid:

Balance Due:

Signature:

Date:

NPI:

Physician or Supplier Information:

Provider ID:

UDI:

Service Facility Location Information:

Billing Information:

NPI:

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**PRINCIPAL PROCEDURE**

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**ADMISSION CONDITION CODES**

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- OTHER PROCEDURE

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**TOTALS**

- OTHER PROCEDURE
- OTHER PROCEDURE

**PAGE ____ OF ____**

**CREATION DATE**

**TOTALS**

**TREATMENT AUTHORIZATION CODES**

- OTHER PROCEDURE
- OTHER PROCEDURE