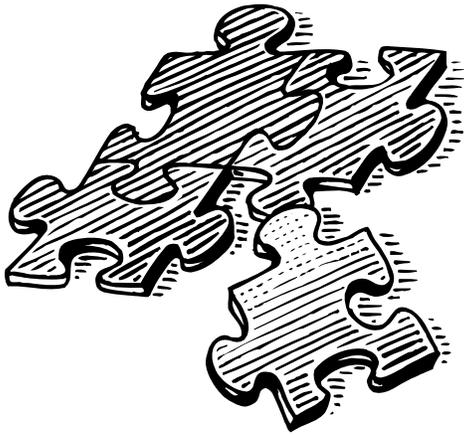


TPL

Handbook



**A guide to
understanding
Third Party Liability**

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This is TPL

The purpose of the Third Party Liability (TPL) program is to reduce Medicaid expenditures. Third parties are entities or individuals who are legally responsible for paying the medical claims of Medicaid beneficiaries. Federal law and regulations require States to assure that Medicaid is to be the payer of last resort. Medicaid beneficiaries are therefore required to utilize all other resources available to them to pay for all or part of their medical needs before turning to Medicaid.

Medicaid must pay primary to:

- *SRS Vocational Rehabilitation Services*
- *Indian Health Services*
- *Crime Victim's Compensation Fund*
- *Children with Special Health Care Needs (CSHCN)– Title V program administered by the Kansas Department of Health and Environment (KDHE)*

TPL is often referred to as 'other insurance'. Other insurance is considered a third party resource (TPR) for the beneficiary.

TPR can also be health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries. Third parties include:

- *Private health insurance **
- *Employment-related health insurance **
- *Medical support from absent parents*
- *Court judgments or settlements from a liability insurer*
- *State worker's compensation*
- *First party probate-estate recoveries*
- *Other Federal programs, (e.g. Medicare, V. A., CHAMPUS, etc.)*

Those with an "" in the list above are the types of insurance that are listed on the MMIS (Medicaid Management Information System) TPL file. Medicare information is listed separate from TPL coverage in the MMIS.*

The Medical Subrogation staff in the KHPA (Kansas Health Policy Authority) Legal Department with the assistance of the fiscal agent staff are responsible for pursuing recovery of Medicaid expenses from automobile and casualty insurance. This can involve court judgments or settlements from the liability insurer. The KHPA Legal Department Estate Recovery staff is responsible for pursuing recovery from the estates of Medicaid beneficiaries.

The focus of this handbook is on health insurance coverage available to Medicaid beneficiaries. It contains basic instructions for gathering TPL information and how it works in the MMIS. It also contains some frequently asked questions (FAQ's) regarding situations that can have a bearing on how and what is entered on the system.

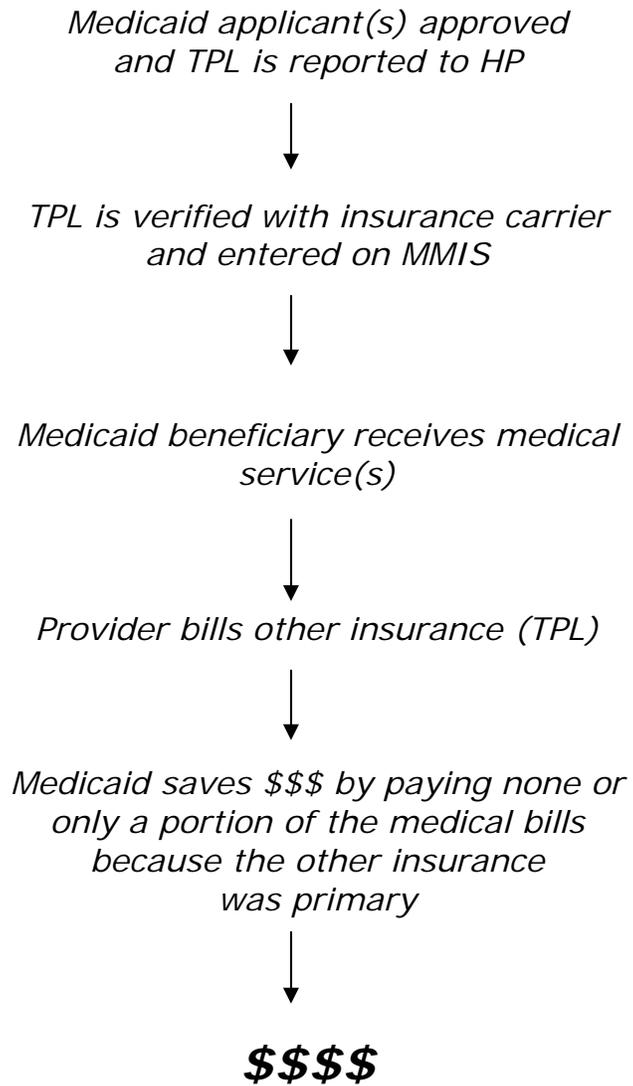
How the MMIS Uses TPL Information

TPL information can originate from several sources. Most commonly they come directly from the beneficiary at the time of application for Medicaid or anytime following approval for benefits. Many leads come from providers through the submission of claims indicating other insurance or a direct referral to the State of Kansas Fiscal Agent (HP Enterprise Services). Leads can also come through a process called post pay billing performed by Health Management Systems (HMS).

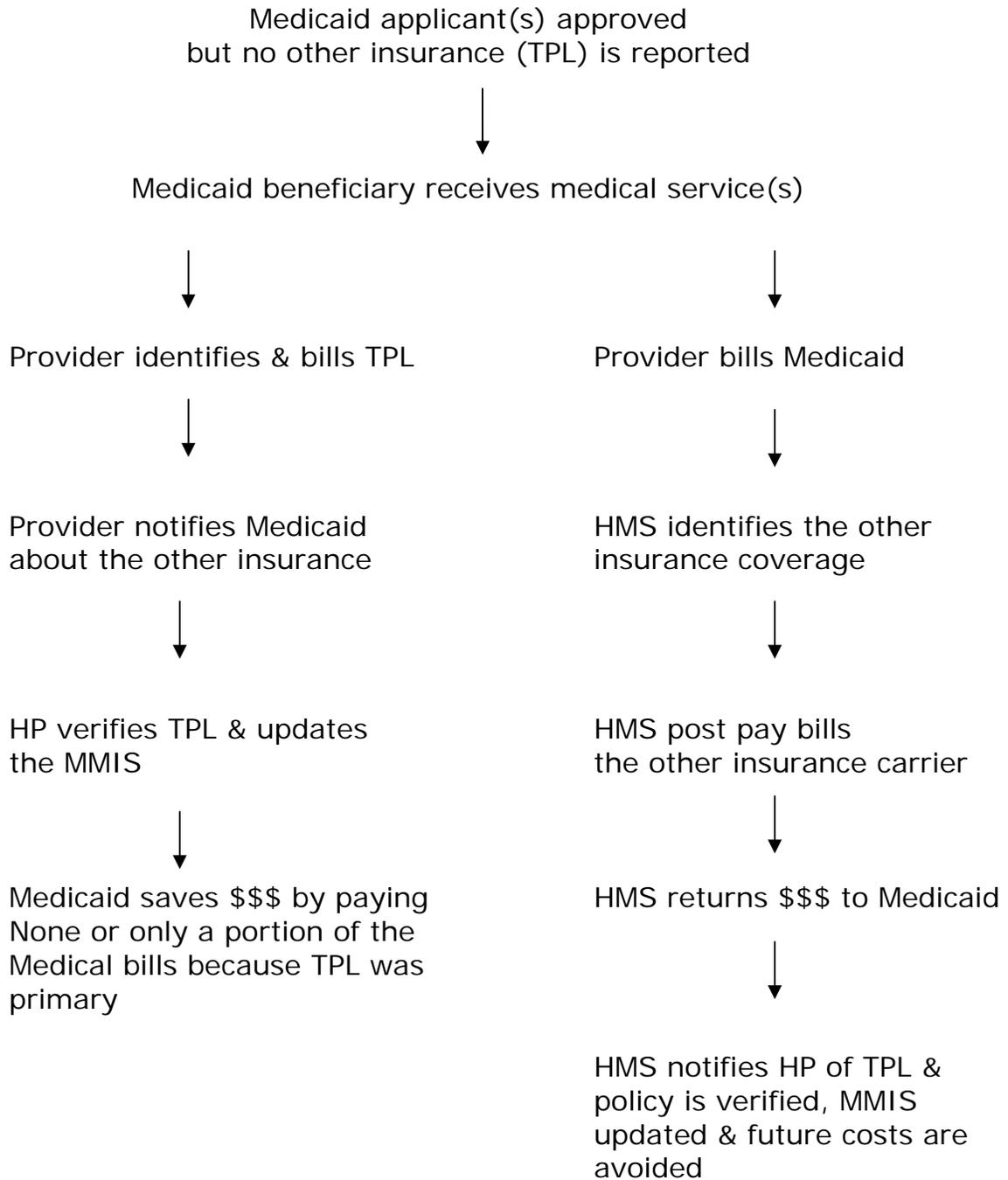
The eligibility worker at the time of application asks many questions to help determine whether there are any other possible resources to pay for medical services before Medicaid must pay. When health insurance coverage is discovered, the eligibility worker asks for and photocopies insurance cards, and refers them to the HP TPL unit for verification. This is a very important step toward ensuring accurate TPL information is in the MMIS from the start.

If the TPL information in the MMIS is inaccurate, it may cause the denial or delayed processing of claims. Providers will attempt to hold the beneficiary responsible for payment of these denied claims until the TPL is accurately input in the MMIS. Complete and accurate information in the MMIS saves dollars, time and worry for everyone.

Ideally, It Works Like This....



But, Sometimes It Works Like This....



Verifying Coverage

Insurance companies will not release information about coverage without relating the information to a specific policy holder. The fiscal agent, HP, verifies all potential TPL leads prior to loading them in the MMIS. The following outlines how the verification process works, and what information is required to successfully pursue a TPL lead.

HP verification steps once a lead is received:

- *Verify Medicaid eligibility within past 3 years*
- *Call the insurance company, or access the plan's website*
- *HP analyst provides pertinent information to access insurance information from the plan*
- *Obtain detailed TPL coverage information, if available*
- *Update the MMIS if appropriate*
- *If information cannot be accessed or verified, then notes are added to the contact tracking system or information is returned to the initiator. This may include a request for additional information.*

Information required for verifying a TPL lead (all):

- *Medicaid beneficiary name and ID number or SSN*
- *Contact name, organization, phone and fax numbers*
- *Name, address and phone of the other insurance company*
- *Policy holder name*
- *Policy holder social security number*
- *Policy holder date of birth*
- *Policy number*
- *Policy group number*
- *Relationship of policy holder to beneficiary*
- *Name of employer (optional)*

Information that HP TPL Analysts verify:

- *Effective dates of coverage*
- *Members covered*
- *Types of coverage*
- *Whether the plan is an HMO or Managed Care*
- *If plan is a Medicare Supplemental*
- *Group number*
- *Employer information*

Complete and Accurate Information

The actual effective dates and termination dates of TPL policies are necessary for claims processing purposes. The post pay billing program checks the last three years of claims history to determine any services on which Medicaid paid and compares them to the effective dates listed on the TPL file. This is especially important for persons who go in and out of Medicaid eligibility.

Even when a policy has terminated, if the individual was Medicaid eligible during the time the policy was in effect, it needs to be updated in the MMIS. Every month the system checks claims up to 3 years old against any new information entered on it and bills insurance companies if the policy was in effect on the date of service.

When TPL resources are identified after claims have paid, HP in cooperation with HMS (Health Management Systems a subcontractor to KMAP), initiates postpayment recovery activities.

Cost Avoidance

Cost Avoidance is the main goal of the TPL program. Once other insurance information is entered on the MMIS, the system will begin cost avoiding claims by denying them back to the provider with a message that the beneficiary has other insurance on that date of service and claims should be filed there first. If the provider has already billed the other insurance, Medicaid will only consider making payment up to the Medicaid allowed amount.

Pay and Chase

Medicaid cannot cost avoid (deny upfront) claims for prenatal, preventive pediatric care, or claims for those KMAP beneficiaries whose insurance is provided by an absent parent. KMAP must pay the claim, then "chase" the other insurance companies for repayment. HMS will post pay bill and recoup from the provider. CSE (Child Support Enforcement) has a process for recoveries from the absent parent in some situations.

In some cases such as domestic abuse and foster care, KHPA's TPL Manager may give approval for KMAP to pay primary to other insurance. Approval from the TPL Manager at KHPA is required before HP staff can set up the TPL coverage in the MMIS with a pay and chase status.

Post Pay Review

The postpayment recovery process closes the TPL loop through a final update to all appropriate TPL beneficiary and carrier databases. Through an interface with HMS, the MMIS generates claim bills that are sent to insurance companies for payment or denial of services.

The post pay billing process occurs monthly. The system generates "Post Pay Bills" or claims to insurance companies. The Post Pay Bills are generated for mandated pay and chase claims and also for claims up to 3 years old for which new TPL coverage information was added to the MMIS.

These post pay bills are generated based on the following criteria:

- *Paid claim status*
- *TPL information on the TPL master file*
- *Other insurance claim indication is zero*
- *Specific claim type*
- *Claim date of service*
- *Services on the claim match coverage code criteria on TPL file*

HMS also generates and mails correspondence to providers notifying them of Medicare coverage and KHPA's recoupment of the Medicaid payment for services also billed to Medicaid. This included Medicare Part A and Part B retroactive eligibility cases and other recovery projects. The unit reviews responses from insurance companies and generates follow-up requests using TPL form letters for additional information as necessary. Medicare does not allow the fiscal agent to post-pay bill so we recover directly from the provider.

Managed Care

Beneficiaries with a Third Party Insurance that is an HMO plan are exempt from assignment to any of the KMAP medical Managed Care Organizations (MCO). When the TPL policy type in the MMIS is managed care it will prevent the beneficiary from being assigned to a KMAP medical MCO. It is vitally important to review the policy coverage carefully to determine if the private insurance is a managed care policy.

MMIS Steps

From the main menu of the MMIS choose the 'Beneficiary' button and the screen shown below will appear. Next enter the beneficiary 11 digit ID number in the 'BID No' field or Social Security Number in the 'SSN' field. If you do not have the ID or SSN, you can search with the beneficiary's name. Click on "Search" and it will bring up the Beneficiary or a list of beneficiaries meeting your criteria. Next, click on "Select" or double click on the beneficiary name. This will bring up the Beneficiary Base screen. Click on the button named "TPL" on the right side of the screen.

Once the TPL Policy Search screen appears, click "Search". A list of all TPL policies will be viewable. Double click or highlight and select the policy of choice for more detail.

The TPL Policy Information screen will provide detailed information of policies in the MMIS. Current policies will show an end date of 2299/12/31 and a Suspect Code of 'valid'. If the policy has been terminated, the policy will show an 'end date'. If some of the case members are active and other members have been terminated, the policy will show an end date of 12/31/2299 in the upper section and a specific end date on the individual member in the lower section. This means the policy is still active, but not for all members of the case. Only policies with a Suspect Code of "valid" are utilized by the system.

To access the definition of the relationship code, double click in the field and the list will appear. For access to other field definitions, click on the 'Select' button in the upper right corner and double click on the field you want to know more about.

Data Matches

Medicare

Medicare is Medicaid's largest third party resource, so the accuracy of this information is very important. The process of adding Medicare coverage to the TPL file is generally automated.

If the analyst suspects Medicare coverage exists, sending a TPQY (Third Party Query) request from EATSS (Easy Access to Social Security) will usually be all the action necessary. The MEIN (Medicare Information) screen in KAECSES (Kansas Automated Eligibility and Child Support Enforcement System) is populated with the Medicare information from EATSS. MEIN is sent to the MMIS nightly and Medicare coverage is then automatically added to the TPL file.

Medicare information appears in a separate section in the MMIS. Users will go to the 'Beneficiary Base' screen, then click on 'Options', choose 'Medicare', and then select 'Medicare Coverage'.

Because MEIN contains data based on Social Security's own information, it is considered accurate and staff is not able to change any segments added through MEIN processing. If inaccurate information is discovered, it should be reported to the Buy-In Specialist at HP Enterprise Services for investigation.

As part of the Medicaid plan, the state is required to provide Medicare Part B coverage to certain groups of individuals. The state pays the standard premium charge on behalf of each enrolled individual. This is accomplished through the buy-in process. Through this process the state ensures entitled individuals are enrolled in Medicare Part B and Medicaid claims are offset by Medicare payments. The state will also pay the Medicare Part A premium for individuals receiving QMB coverage.

Public Assistance Reporting Information System (PARIS)

PARIS is a federal and state partnership that collects, houses and matches public assistance eligibility information to improve program integrity amongst participating states. PARIS is administered by the U.S. Department of Health and Human Services, Administration for Children and Families (ACF). Data files are sent by individual states to ACF for data matching at least once a year and up to four times. SRS receives this report, and the 'other insurance' section on this report is provided to the fiscal agent who is responsible for verifying the lead and updating the MMIS.

Health Insurance Premium Payment System (HIPPS)

The HIPPS program is a Medicaid program that reimburses for the cost of premiums, and cost sharing expenses (coinsurance and deductibles) for beneficiaries who have health insurance through their employer. The program reimburses the insurance premium for Medicaid eligible persons when it is determined to be cost effective.

The cost effectiveness determination means the cost of paying the policy's premiums is deemed to be less expensive than paying for the care with only Medicaid funds. The MMIS has a program which utilizes key factors (peer groupings) in making the determination of cost effectiveness. In addition to the cost analysis, the HIPPS analyst can also consider the specific health related circumstances of the household. Those expected expenses are compared to the services covered under the policy, the cost of premiums, coinsurance and deductible. If the combined insurance costs are less than what Medicaid would spend for those same services, it is cost effective to purchase it.

Arrangements are made for Medicaid to pay the health insurance premium directly to the insurance carrier or employer whenever possible. However, if the only mechanism for premium payment is through payroll deduction, the beneficiary will be reimbursed directly for the deduction made for health insurance.

The HIPPS program will continue to pay the premiums as long as the beneficiary remains eligible for Medicaid and as long as it remains cost

effective to do so. A review is performed every six months by the HIPPS staff. When there is a change in the services covered, who is covered, or an increase in the cost of the premium, the policies are reevaluated for cost effectiveness.

If the policy is cost effective, Medicaid beneficiaries are required to participate in the plan as a condition of Medicaid eligibility. Having coverage under a HIPPS policy does not mean they will receive no Medicaid benefits. Medicaid still pays for Medicaid covered services that the insurance policy does not.

Failure to cooperate with the HIPPS process may result in loss of eligibility for the beneficiary. Please refer to KEESM for exceptions or questions.

FAQ's

Frequently Asked Questions

1.) What is TPL?

Third Party Liability – these parties are entities or individuals who are legally responsible for paying the medical claims of Medicaid beneficiaries. The purpose of the TPL program is to reduce Medicaid expenditures.

2.) What is Cost Avoidance?

Cost Avoidance is the main goal of the TPL program. Once other insurance information is entered on MMIS, the system will begin cost avoiding claims by denying them back to the provider with a message that the beneficiary has other insurance on that date of service and claims should be filed there first.

3.) What do I do if I discover a beneficiary has TPL?

Notify the fiscal agent (HP) by faxing a completed TPL Submission form (attached at the end of this document) to:

HP Fax - 785-274-5918

4.) What is needed by TPL/HP to verify a lead?

Information required to verify a lead:

- Medicaid beneficiary ID number or SSN
- Contact name, organization, phone and fax numbers
- Name, address and phone of other insurance company
- Policy holder name
- Policy holder social security number
- Policy holder date of birth
- Policy number
- Policy group number
- Relationship of policy holder to beneficiary

Information HP TPL Analysts verify:

- Effective dates of coverage
- Members covered
- Types of coverage
- HMO or Managed Care
- Medicare Supplemental
- Group number
- Employer information

5.) What if a beneficiary has access to employer based insurance?

The HIPPS program is a Medicaid program that reimburses for the cost of premiums, and cost sharing expenses (coinsurance and deductibles) for beneficiaries who have health insurance through their employer.

The program reimburses the insurance premium for Medicaid eligible persons when it is determined to be cost effective.

Arrangements are made for Medicaid to pay the health insurance premium directly to the insurance carrier or employer whenever possible, but can be made to the beneficiary in some situations.

Interested beneficiaries can call:

HIPPS - 800-967-4660

6.) What are the advantages of being in the HIPPS Program?

- *The insurance policy may cover services not covered under Medicaid*
- *Sometimes buying a family plan for the Medicaid eligible person(s) is cost effective, and members of the family who are not eligible for Medicaid also benefit from the health insurance coverage*
- *Health insurance will be available if Medicaid eligibility is lost, although Medicaid will no longer be paying the premiums*
- *It can save money for Kansas Medicaid*

7.) What determines whether a claim is pay and chase?

Medicaid is federally mandated to pay and chase claims or prenatal, preventive pediatric care and for those whose insurance is provided by an absent parent. Additionally, the KHPA TPL Program Manager can request HP to change a TPL policy to pay and chase if determined to be appropriate.

The MMIS compares the procedure codes on claims to a list of identified prenatal and preventive pediatric codes to determine whether the claim should pay and chase.

The MMIS uses the relationship code of 'F' to determine if the insurance coverage is held by an absent parent. These claims are set to pay and chase.

If you feel you have a situation that warrants consideration by the KHPA TPL Program Manager, send an email detailing the situation to:

LOC-KSXIX-TPL-DistributionList@external.groups.hp.com

8.) What makes a policy HMO (Managed Care)?

HMO and managed care policies usually require the persons insured to use a physician and other medical services provided they are in their network of providers. These providers are under contract to the HMO to accept the plan's schedule of payment for services. If there are no restrictions on what providers are used, the plan is not considered an HMO or managed care plan. The surest way to gather that information is to ask during the verification process with the insurance company.

Glossary

| | |
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| Assignment of Benefits | <i>A method under which a claimant requests that his/her benefits under a claim be paid to some designated person or entity, e.g., a physician, hospital, Medicaid, etc.</i> |
| Beneficiary | <i>To the insurance company, a person designated by an insuring organization as eligible to receive insurance benefits.</i> |
| Benefit | <i>A service allowed for coverage/financial reimbursement provided under an insurance policy or prepayment system.</i> |
| Benefit Package | <i>Services an insurer, government, agency or health plan offers to a group or individual under the terms of a contract.</i> |
| Capitation | <i>The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a healthcare provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider.</i> |
| Carrier | <i>An entity which may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.</i> |
| Catastrophic | <i>Insurance beyond basics and major medical insurance for severe and prolonged illness which poses a severe financial threat. Cancer policies are this type.</i> |
| Coinsurance | <i>The portion of covered healthcare costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.</i> |

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| <i>Copay/copayment</i> | <i>A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as \$10 for an office visit. The covered person is usually responsible for payment at the time the healthcare is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services. Some copayments are referred to as coinsurance, with the distinguishing characteristics that copayments are flat or variable dollar amounts and coinsurance is a defined percentage of the charges for services rendered.</i> |
| <i>Cost-effectiveness</i> | <i>A study to determine the overall ratio of cost to benefit.</i> |
| <i>Cost sharing</i> | <i>A general set of financing arrangements via deductibles, copays and/or coinsurance in which a person covered by the health plan must pay some of the costs to receive care.</i> |
| <i>CSE</i> | <p>The Kansas Child Support Enforcement (CSE) is a SRS program that helps families with children by:</p> <ul style="list-style-type: none"> ▪ Enforcing child support orders; ▪ Locating absent parents and their property; ▪ Getting an order of paternity, if the father needs to be identified legally; ▪ Getting an order for cash child support, if needed; ▪ Getting and enforcing an order for health insurance coverage for a child, if needed; and ▪ Watching to make sure support payments come in regularly. |
| <i>Deductible</i> | <i>The amount of eligible expense a covered person must pay each year from his/her own pocket before the plan will make payment for eligible benefits.</i> |
| <i>Dependent</i> | <i>An individual who relies on an employee for support or obtains health coverage through a spouse, parent or grandparent who is the covered person.</i> |

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| Eligibility date | <i>The defined date a covered person becomes eligible for benefits under an existing contract.</i> |
| Fiscal Agent | <i>A fiscal agent is a contractor that processes or pays vendor claims on behalf of the Medicaid agency. The current fiscal agent for Kansas Medicaid is HP Enterprise Services (HP).</i> |
| Group | <i>A collection of individuals treated as a single entity; usually, an employer purchasing medical coverage on behalf of its full-time employees.</i> |
| Group Insurance | <i>Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.</i> |
| HIPPS | <i>Health Insurance Premium Payment System, a program which pays for Medicaid beneficiaries group health insurance available through employment if it is cost effective to do so.</i> |
| HMO | <i>Health Maintenance Organization. An entity that provides offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.</i> |
| Hospice | <i>A licensed or certified facility or program engaged in providing palliative and supportive care of the terminally ill.</i> |
| Long term care Insurance | <i>Insurance coverage designed to help pay some or all of any necessary long term care costs.</i> |
| Income Indemnity Plan | <i>Plan benefits are not designated for medical care and are not used to pay for medical care. This plan is not entered into the MMIS.</i> |

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| Major medical | <i>Insurance designed to cover expenses of serious illness, chronic care, and/or hospitalization (chronic care is delineated from long term care which is most often not covered by major medical policies).</i> |
| Managed care | <i>1)A system of healthcare delivery that influences utilization and cost of services and measures performance. The goal is a system that delivers value by giving people access to high quality, cost-effective healthcare; 2)A systemized approach which seeks to ensure the provision of the right healthcare at the right time, place and cost.</i> |
| Medical Indemnity Plan | <i>Policy specifics benefits are to be used for medical care. If all or part of the benefits payable are designated for or used by the policyholder for medical services covered under Medicaid, enter the plan on the MMIS.</i> |
| Medicare Part A | <i>(Hospital Insurance) - Provides coverage of inpatient hospital care, hospice and home health benefits. Very limited coverage of skilled nursing facility care is also provided. Part A coverage does not have a premium for most people.</i> |
| Medicare Part B | <i>(Supplemental Medicare Insurance) – Provides coverage of doctors services, outpatient hospital care. Part B also provides coverage for other services such as clinical laboratory services, some therapies, and certain preventative services. Most people pay a monthly premium for Part B coverage through a withholding from their Social Security or Railroad Retirement benefit.</i> |
| Medicare Part C | <i>(Medicare Advantage) – Provides coverage under a managed care model and is only open to people who in an area of the state where a plan is offered. Persons receiving Medicare through an Advantage plan agree to receive services from a contracted network of providers but may have additional services covered (such as dental). They may also have an additional premium for coverage.</i> |

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| Medicare Part D | <i>(Prescription Drug Insurance) – Provides coverage of outpatient prescriptions drugs. Medicare beneficiaries will receive Part D coverage through a private plan, known as a Prescription Drug Plan (PDP). A Medicare health plan can also provide coverage under Part D, Medicare Advantage – Prescription Drug (MA PD). All plans must offer prescriptions drugs in specified therapeutic drug classifications, but the specific formularies may vary. Beneficiaries eligible to enroll in Part D must do so through the private plan. A monthly premium is charged to the beneficiary and is collected through a reduction in the Social Security benefit or paid directly to the PDP.</i> |
| Medicare Supplement Policy | <i>A policy guaranteeing that a health plan will pay a policyholder's coinsurance, deductible and copayments and will provide additional health plan or non-Medicare coverage for services up to a predefined limit. In essence, the product pays for the portion of the cost of services not covered by Medicare. Also called "Medigap" or "Medicare wrap".</i> |
| Members | <i>Participants in a health plan (subscribers or enrollees and eligible dependents), who make up the plan's enrollment. "Member" also is used to describe an individual specified within a subscriber contract that may or may not receive healthcare services according to the terms of the subscriber policy.</i> |
| MMIS | <i>Medicaid Management Information System – The system designed for Title XIX claims processing and information retrieval as described in Chapter 11 of the State Medicaid Manual by the U. S. Department of Health and Human Services.</i> |
| O/I | <i>Other insurance. Health insurance other than Medicaid.</i> |
| PH | <i>Policy Holder</i> |

| | |
|---------------------------|---|
| PHR | <i>Policy Holder Recovery</i> |
| Plan | <i>Refers in this context to health plans, an HMO or insurance agency.</i> |
| Post Pay Bill | <i>The MMIS sends a Post Pay Bill or claim to insurance companies when it finds TPL on the file that is effective for the dates of service on claims which it already paid.</i> |
| Primary Coverage | <i>The coverage plan which considers and pays its eligible expenses without consideration of any other coverage.</i> |
| Secondary Coverage | <i>The plan that has the responsibility for payment of any eligible charges not covered by the primary coverage. Medicaid is generally secondary to all other health insurance.</i> |
| Subrogation | <i>A procedure under which Medicaid can recover from any liable third party all or some proportionate of benefits paid to a Medicaid beneficiary or person responsible.</i> |
| Termination Date | <i>The date that a group contract expires; or, the date that a subscriber and/or covered person ceases to be eligible.</i> |
| TPL | <i>Third Party Liability – some other entity liable to pay medical expenses before Medicaid. For the purposes of this handbook, TPL means health insurance.</i> |
| TPL Segment | <i>Insurance coverage related to a specific policy and its effective and termination dates. One person can have several TPL Segments active at the same time. One segment may be a policy for hospital and medical coverage, another segment could be the pharmacy coverage, and yet another segment the dental coverage.</i> |

TPR

Third Party Resource – another entity or person who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries

**Workers
Compensation**

A state-governed system designed to address work-related injuries. Under the system, employers assume the cost of medical treatment and wage losses arising from a worker's job-related injury or disease, regardless of who is at fault.

Kansas Medical Assistance Programs

P.O. Box 3571
Topeka, KS 66601-3571

From the office of the Fiscal Agent

Please complete form and fax to HP TPL Unit at (785) 274-5918 or email to
Loc-ksxix-tpl-distributionlist@external.groups.hp.com

Contact Name _____ Contact Organization _____
Contact Phone _____ Contact Fax _____

NOTE: The above information is necessary so we may contact you if there are questions related to this referral.

Insurance Policy Information

| | |
|---|-----------------------------------|
| Add / change policy [] Delete policy [] | |
| Name of Other Insurance Company _____ | |
| Street Address _____ | |
| City _____ | State _____ Zip Code _____ |
| Phone _____ | |
| Policy Holder Name _____ | |
| Policy Holder Social Security Number _____ | |
| Policy Holder Date of Birth _____ | Policy Number _____ |
| Policy Group Number _____ | Relationship to Beneficiary _____ |

NOTE: This box **must** be complete in order for insurance information to be added. Failure to complete all fields will result in the form being returned.

KMAP Beneficiary Information

| Name of Beneficiary | KMAP ID Number | Relationship to Policy Holder |
|---------------------|----------------|-------------------------------|
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Facsimile transmission and attachments, if applicable, contain protected health information (PHI). This information is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential and any use, disclosure, or reproduction of this information is prohibited. If you receive this communication in error, please contact the "Contact" person named above.

Ms-2505 TPL Primary