MO HEALTHNET DIVISION

THIRD PARTY RESOURCE FORM (TPL-1)

INSTRUCTIONS FOR FAMILY SUPPORT DIVISION

PURPOSE: The purpose of the TPL-1 form is to provide Medicaid participants' current health insurance information to the MO HealthNet Division (MHD). The health insurance information provided on the TPL-1 enables MHD to recover medical expenses paid on individuals with private health insurance.

The TPL-1 form is sent to MHD so the information can be verified with the insurance company. It is important that you provide the correct policy information so that it can be verified accurately.

Complete TPL-1s for the following types of health insurance:

- Self-insured labor unions, welfare funds, or employers;
- Medicare supplements, Medigap, or "tie-in" policies;
- Health Maintenance Organizations (HMOs), Preferred Provider Organization (PPO), or Prepaid Health Plans (PHP);
- Any commercial health insurance policy;
- Hospital indemnity policies (see #3 in list below);
- TRICARE;
- Accident insurance - covers hospital, physician or other medical care that is incurred as a result of an accident;
- Cancer Policy
- Other health insurance coverage riders (i.e., separate plans for vision, dental, pharmacy, etc.)

Do NOT complete TPL-1s for the following:

- MO HealthNet Managed Care Plans
- Medicare
- Wage or income replacement policies (not the same as hospital indemnity).
- Disability policies
- Life insurance
- Burial insurance
- Automobile insurance
- Loss of limb or dismemberment policies, trip or travel accident policies, short duration or location-specific accident policies such as school accident.

Certain information is required by MHD to identify the policy with the insurance company. The following is the minimum data required for verification; however, the more information you can provide, the more accurate and timely the verification can be.

Required Data:

- Insurance company name and address
- Employer name and address.
- Policyholder's name.
- Policy number.
- Social Security number of the policyholder, if the policy number is not the Social Security number.

To access the Insurance Database screens through FAPC on the State system, use MTPR and MCII

- MTPR - Insurance company name and address, policy holder, begin and end dates;
- MCII – MO HealthNet screen

Note: Prior to completion of a TPL-1 form, check the MTPR screen(s) for insurance information in the TPL Data Base.

Complete the TPL-1 form only if the insurance information in the TPL Data Base needs to be updated or if additional insurance coverage needs to be added.

- MHD must be able to read what you have written on the TPL-1. If the entry cannot be read, the form cannot be processed correctly and it will be returned to you to be rewritten.

- **Email completed TPL-1 form to: tpl.database@dss.mo.gov with the subject line of "TPL Update" or Fax to 573-526-1162. File a copy in the electronic case record (ECM).**

INSTRUCTIONS FOR COMPLETION: Below is an explanation of each field, with hints for completing the TPL-1.

- **Field 1 PAY COUNTY**. Enter the three-digit numerical code indicating the county where the case is currently active (this can be located on **SCMBR** next to **DFS OFFICE**).
- **Field 2 TYPE OF ASSISTANCE (T/A).** Enter the appropriate letter code for the type of assistance received (MPW/MHK/MHF/UWHS/MHSD/MHNS ETC).
- **Field 3 CASE DCN.** Enter the 8 digit DCN of the HOH the medical case is active under.
- **Field 4 ELIGIBILITY SPECIALIST NAME**. The worker completing the TPL-1 should enter his/her NAME in this field.
- **Field 5 DATE (MM/DD/YY).** Enter the current date.
- **Field 6 REQUESTED ACTION**. If this policy is not on the MTPR screen mark “ADD NEW RESOURCE”. If this policy is on the MTPR screen and needs to be updated, mark “CHANGE RESOURCE FILES”
- **Field 7 PARTICIPANT’S NAME**. Enter the name of each MHN eligible participant in the case who is covered by insurance. For example, each eligible person on a MHK/MHF/MPW/UWHS/MHNS/MHSD etc. case with insurance coverage.
- **Field 8 MEDICAID ID NUMBER**. Enter the eight-digit DCN of the participant who is listed in field 7.
- **Field 9 RELATIONSHIP to POLICYHOLDER**. Enter the appropriate relationship from the list below (match the relationship code located on MTPR to code listed below and enter the relationship).

(The relationship of the participant to the policyholder)

- 00-SELF
- 01-SPOUSE
- 04-GRANDPARENT
- 05-GRANDCHILD
- 07-NEPHEW/NIECE
- 17-STEP CHILD
- 19-CHILD
- 19C-COURT ORDERED CHILD
- 32-MOTHER
- 33-FATHER

- **Field 10 INSURANCE COMPANY NAME**. Please enter the complete company name. Do not abbreviate important portions of the name or use acronyms. It is acceptable to abbreviate "Insurance Company" to "Ins Co".

- **Field 11 EMPLOYER/GROUP NAME.** The name of the policyholder's employer or the organization (union, government, military, school, etc.) is entered in this field when the policy is through a group plan. This is a required field if policy is through a group plan.
- **Field 12 INSURANCE COMPANY ADDRESS (STREET)**. Enter the street address of the insurance company listed in field 10.
- **Field 13 EMPLOYER/GROUP ADDRESS (STREET)**. Enter the street address, city, state and ZIP code for the employer or group listed in field 11. This is a required field if policy is through a group plan.
- **Field 14 INSURANCE COMPANY ADDRESS (CITY, STATE, ZIP CODE).** Enter the city, state and zip code for the insurance company listed in field 10.
- **Field 15 EMPLOYER/GROUP ADDRESS (CITY, STATE, ZIP CODE).** Enter the city, state and zip code for the employer or group listed in field 11. This is a required field if policy is through a group plan.
- **Field 16 POLICYHOLDER'S NAME (REQUIRED FIELD)**. The policyholder is the person in whose name the policy is listed with the insurance company.
- **Field 17 POLICYHOLDER'S DATE OF BIRTH (REQUIRED FIELD).** Enter the date of birth of the name listed in field 16.
- **Field 18 POLICYHOLDER'S SOCIAL SECURITY NUMBER (REQUIRED FIELD)**. Enter the social security number of the name listed in field 16.
- **Field 19 POLICYHOLDER'S ADDRESS (STREET).** Enter the street address of the name listed in field 16.
- **Field 20 POLICYHOLDER'S ADDRESS (CITY, STATE, ZIP CODE).** Enter the city, state and zip code of the name listed in field 16.
- **Field 21 POLICY NUMBER (REQUIRED FIELD)**. Enter the policy number. EVERY EFFORT MUST BE MADE TO OBTAIN THE POLICY NUMBER. If you have access to the health insurance card, it will include the policy number. The verification worker must have the policy number to identify the policy with the insurance company. Often, the policy number will be the Social Security number of the policyholder.
- **Field 22 GROUP NUMBER**. This number identifies the specific employer or organization with the insurance company.
- **Field 23 ELIGIBILITY SPECIALIST/SUPERVISOR SIGNATURE.** Enter the name of the person completing this form.
- **FIELD 24 PHONE NUMBER.** Enter the phone number of the person listed in field 23.
- **FIELD 25 ADDITIONAL COMMENTS.** Enter any comments here.
- **FIELD 26 TO BE COMPLETED BY THE THIRD PARTY LIABILITY UNIT.** Do not enter anything.