



DEPARTMENT OF SOCIAL SERVICES
 DIVISION OF MEDICAL SERVICES
THIRD PARTY RESOURCE FORM

PAY CO	TOA	CASE DCN	ELIGIBILITY SPECIALIST NUMBER	DATE (MM/DD/YY)
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CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION

ADD NEW RESOURCE OR CHANGE RESOURCE FILES

RECIPIENT NAME	MEDICAID ID NUMBER (DCN)	*RELATIONSHIP TO POLICYHOLDER
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RECIPIENT NAME	MEDICAID ID NUMBER (DCN)	RELATIONSHIP TO POLICYHOLDER

* EXAMPLES OF RELATIONSHIP TO POLICYHOLDER: SELF, SPOUSE, GRANDPARENT, GRANDCHILD, NEPHEW, NIECE, STEPCHILD, CHILD, COURT ORDERED CHILD, MOTHER, FATHER, SIGNIFICANT (SIG) OTHER

INSURANCE COMPANY NAME		EMPLOYER NAME
INSURANCE COMPANY ADDRESS (STREET)		EMPLOYER ADDRESS (STREET)
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE
POLICYHOLDER'S NAME (REQUIRED FIELD)	POLICYHOLDER'S DATE OF BIRTH (REQUIRED FIELD)	POLICYHOLDER'S SOCIAL SECURITY NUMBER (REQUIRED FIELD)
POLICYHOLDER'S ADDRESS (STREET)		CITY, STATE, ZIP CODE
POLICY NUMBER (INCLUDE ANY/ALL ALPHA PREFIX INFORMATION) (REQUIRED FIELD)		GROUP NUMBER
ELIGIBILITY SPECIALIST/SUPERVISOR SIGNATURE		PHONE NUMBER

ADDITIONAL INFORMATION

TO BE COMPLETED BY THE THIRD PARTY LIABILITY UNIT

This TPL-1 cannot be processed as requested. Below is information regarding verification of this policy. Please read and complete items as requested. Return the TPL-1 and any attachments to the TPL Unit as soon as possible so the information can be verified and entered into the TPL database. If you have any questions, please contact the TPL Unit at (573) 751-2005.

- Per verification with the insurance company, dependent(s) are are not covered on this policy. If this is not correct, the client needs to contact the insurance company.
- Additional information is required in order to verify coverage. Please attach copies of any documentation you have, i.e., insurance card, which could help identify the policy.
- No action requested.
- Unable to read, please re-submit.
- Form not complete enough for verification by state. Complete highlighted areas and re-submit.
- Other