Third Party Resource Transmittal

Program Affected (check one) Medicaid ____ NCHC ____ BCCM ____

Applicant/Recipient Information

Recipient Name _____
MID # _____
Case ID # _____

Insurance Information

Name of Insurance Company _____
Policy Number _____
Policy Holders Name _____

Reason the Insurance is Invalid or Non-applicable

____ The individual never had the insurance.
____ The policy ended __/__/____.
____ The policy is not comprehensive coverage.
____ The policy does not have a participating provider in the individual's county of residence.
____ Other _____

County Reporting the Error _____
Worker Name and Phone # _____

This form and accompanying verification must be FAXed to Third Party Recovery, Attention: Program Integrity Contract Administrator at (919) 715-4725.