

## Third Party Liability (TPL)

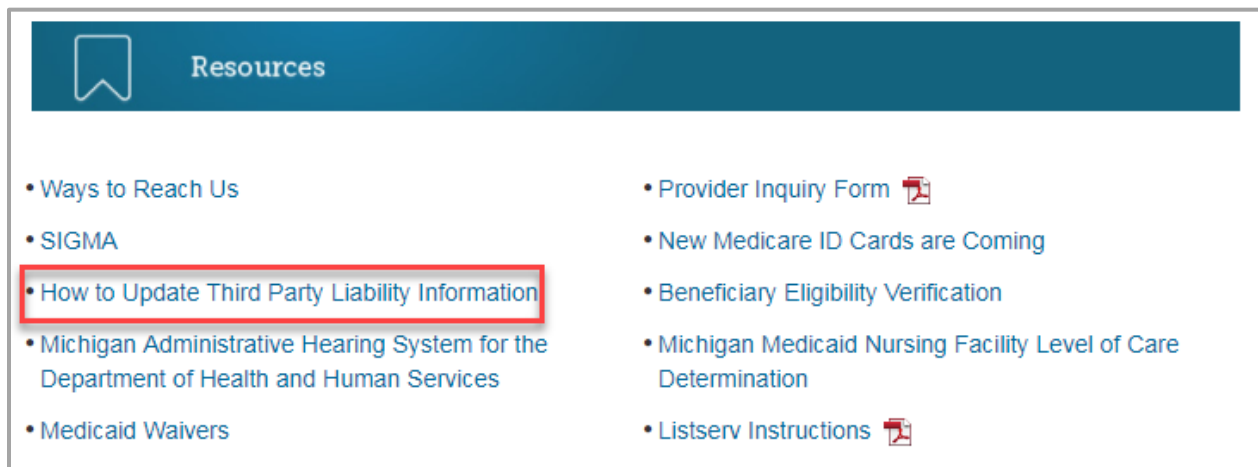
### Adding, Removing, and Updating TPL Files within CHAMPS

There will be times when a provider disputes information in a beneficiary's TPL file. Providers can utilize the Insurance Coverage Request Form (DCH-0078) to add, remove, or update TPL files within CHAMPS. Below are the steps for locating the [Insurance Coverage Request Form](#).

Please note: This form is not accepted for BCBSM, BCN or Delta Dental.

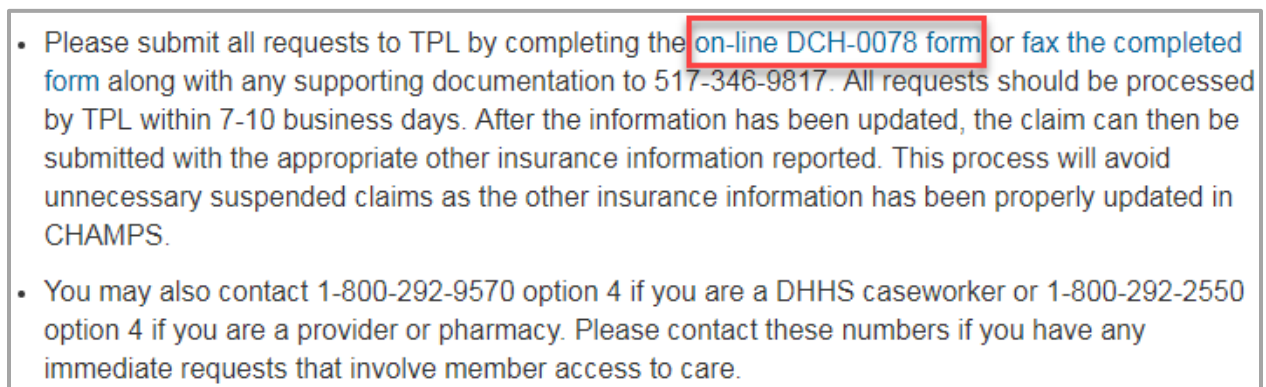
**Step 1:** Go to the following website: <http://www.Michigan.gov/MedicaidProviders>

**Step 2:** Scroll down to Resources, click [How to Updated Third Party Liability Information](#)



The screenshot shows a website interface with a dark blue header containing a bookmark icon and the word "Resources". Below the header is a list of resource links. The link "How to Update Third Party Liability Information" is highlighted with a red rectangular box. Other links include "Ways to Reach Us", "SIGMA", "Michigan Administrative Hearing System for the Department of Health and Human Services", "Medicaid Waivers", "Provider Inquiry Form", "New Medicare ID Cards are Coming", "Beneficiary Eligibility Verification", "Michigan Medicaid Nursing Facility Level of Care Determination", and "Listserv Instructions".

**Step 3:** Click on the online [DCH-0078 form](#)



The screenshot shows a list of instructions. The first bullet point states: "Please submit all requests to TPL by completing the on-line DCH-0078 form or fax the completed form along with any supporting documentation to 517-346-9817. All requests should be processed by TPL within 7-10 business days. After the information has been updated, the claim can then be submitted with the appropriate other insurance information reported. This process will avoid unnecessary suspended claims as the other insurance information has been properly updated in CHAMPS." The phrase "on-line DCH-0078 form" is highlighted with a red rectangular box. The second bullet point states: "You may also contact 1-800-292-9570 option 4 if you are a DHHS caseworker or 1-800-292-2550 option 4 if you are a provider or pharmacy. Please contact these numbers if you have any immediate requests that involve member access to care."

**Step 5:** Fields marked with an asterisk are required. Providers are encouraged to use the highest level of demographic information available (e.g., policy name, policy number, policyholder etc.). This allows Third Party Liability (TPL) to validate the policy information reported for possible addition, removal, or updates to the beneficiary's TPL file.

Please Note: It is very important for providers to select the correct **Request Type** and **Insurance Company Name** on the online form.



## Insurance Coverage Request Form

This form is utilized to add, terminate or change multiple insurance policy information for a beneficiary. **Please add all beneficiary information, as well as all policy holder information.** Multiple beneficiaries can be added to this request, as long as the changes are identical for the beneficiaries included on this form. Please complete as much information as possible to ensure timely completion. All required information is needed in order for this form to be submitted. Submitted forms that are missing information may not be reviewed.

You will receive a confirmation message and confirmation number indicating that your information has been received. Please allow up to 10 business days for information to be verified and updated in the system. **If you include your e-mail address under the Requestor Information section** you will receive an e-mail along with the confirmation number and the status of your request, once it has been reviewed and completed.

To report this information by phone, please contact Provider Support at 1-800-292-2550.

### Requestor Information

[Reset Requestor Information](#)

Remember Me [?](#)

**First Name \*** Requestor First Name

**Last Name \*** Requestor Last Name

**Organization Type \*** Select a Organization Type

**Organization Name** Requestor Organization Name

**Phone Number \*** Requestor Phone Number [?](#)

**Email Address** Requestor Email Address

### Member Information

Member #1

[Reset Member #1](#)

**First Name \*** Beneficiary/Client First Name

**Last Name \*** Beneficiary/Client Last Name

**Date of Birth \*** mm/dd/yyyy [?](#)

**MiHealth ID \*** Beneficiary/Client MiHealth ID Number, Format: Up to a 10 digit number

**Case Number** Beneficiary/Client Case Number

[+ Add Another Member](#) [?](#)

### Policy Information

**Request Type\***

**Coverage Type\***

Policy #1 Reset Policy #1

**Insurance Company Name\***

**Policy Number**  !

**Group Number**

**First Name**  !

**Last Name**  !

**Date of Birth**  !

**Social Security Number**

**Employer Name**

?

### Additional Information

**Comments**

This request is in response to a Claim Void Letter

**Step 6:** Once the form is complete the provider will need to click **Submit** at the bottom of the form.

Please allow up to 10 business days for the information to be verified and updated in the system. If you include your e-mail address under the Requestor Information section you will receive an e-mail along with the confirmation number and the status of your request, once it has been reviewed and completed.