Third Party Carrier Code Request

Date:

This form is to be used only for requesting that a commercial carrier be added to the Carrier Code List in

Appendix C. For additional clarification, please refer to All Provider Bulletin 201 (February 2010).

Do not use this form to report an update in third-party insurance for a MassHealth member. To

update a member’s insurance information, please continue to use the Third Party Liability Indicator form,

which can be found in the Provider Library, under MassHealth Provider Forms.

1. Commercial Carrier Information

 Insurance Company Name:

 Insurance Company Phone No.:

 Insurance Company Address:

2. Policyholder and Family Information

 Policyholder’s Name:

 SSN: Date of Birth:

 Policy No.: Group No.:

 Policy Start Date: Policy End Date:

 Family Members Covered:

 Name: MassHealth ID No.:

 Name: MassHealth ID No.:

 Name: MassHealth ID No.:

 Name: MassHealth ID No.:

3. Provider Information

 Provider Name:

 Contact Person:

 Contact Phone No.:

 Contact Fax No.:

Please fax this form to:

617-886-8134Assistant ManagerRevenue Operations Benefit Coordination

TPCCR (Rev. 03/10)