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:

617-886-8134

Assistant Manager
Revenue Operations Benefit Coordination