Secondary Insurance Claims

Submit an individual coversheet for each claim

**Provider Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **MCI No**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Admission Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Discharge Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Service**:  Inpatient Hospitalization  Partial Hospitalization

Documentation submitted with coversheet must include:

Intake

Admissions Summary

Discharge Summary

Copy of Explanation of Benefits from Primary Insurer

Fax or email a ***complete*** package to:

Eartha Hopkins

Fax~ 302-622-4475

Email ~[DSCYF\_DPBHS\_Invoicing@delaware.gov](mailto:DSCYF_DPBHS_Invoicing@delaware.gov)