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