INSURANCE ISSUE

State Form 54962 (4-12)

CLUSTER:	Today's date *(month, day, year)*:

SERVICE POINT OF ENTRY (SPOE) SUBMISSION GUIDELINES

1. Please complete each section of the form as completely as possible. *Incomplete issue forms cannot be reviewed without the minimum information included.
2. Submit this form, along with any other necessary documentation to FirstStepsWeb@fssa.in.gov . The subject of the email should be in this format – 'AInsuranceIssuemm/dd/yylastname.' (The letter at the beginning should correspond with your cluster letter, and the last name refers to the last name of the child.)
3. Once your complete insurance issue has been received, it will be reviewed, and processed in approximately 10-12 business days. Issues that cannot be resolved within this timeframe will be responded to within this timeframe, with additional instructions or directions for next steps.
4. For insurance billing waiver requests, a letter requesting a waiver which includes the child(ren) information and documentation demonstrating/confirming Employee Retirement Income Security Act (ERISA) or non-ERISA plan should be attached with this form.
5. Please attach any related documentation or pertinent information identified as part of the SPOE review which may be helpful in reviewing this form submission.

FAMILY INFORMATION

Name of parent		
Name of child*		Date of birth *(month, day, year)**
Service Point of Entry identification*		
Address *(number and street, city, state, and ZIP code)**		
Home telephone number ( )	Alternate telephone number ( )	E-mail address

SERVICE POINT OF ENTRY (SPOE) / SERVICE COORDINATOR SUMMARY

Name of Service Coordinator*	Date of submission *(month, day, year)**
Service Point of Entry contact e-mail address*	Telephone number ( )
Summary of insurance issue*	

ISSUE REVIEW STEPS COMPLETED

Does this issue require a correction or revision to the family's cost participation? ⇨	☐ Yes Accepted Cost Participation Rate: _____ Corrected Cost Participation Rate: _____ *(if applicable)* Cost Participation effective date *(month, day, year)*: _____ Other revision *(please attach detail)*: _____	☐ No

Verify the correct insurance information recorded in the Service Point of Entry database*
☐ Yes, this was verified. ☐ Yes, the carrier effective date was verified with the family.

Insurance Carrier Information

Has the family already contacted the Central Reimbursement Office for assistance via the helpdesk?* ☐ Yes ☐No

Detail

Can the answer to the family's question be answered by logging on to Provider Account Management?* ☐ Yes ☐ No	**Please attach any relevant PAM information with this submission.**

Verify you have the correct, most complete, diagnosis codes in Service Point of Entry?* ☐ Yes, this was verified.

Summary of Codes

Please list attachments included with this insurance issue.

Signature of Service Point of Entry Supervisor	Date *(month, day, year)**