CLAIM TO DEFRAY FUNERAL AND CEMETERY EXPENSES

State Form 35937 (R7 / 09-26)
FAMILY AND SOCIAL SERVICES ADMINISTRATION

Claimant must complete, sign and date form. Submit to Family and Social Services Administration (FSSA), Division of Family Resources (DFR), within ninety (90) days of date of death. Instructions on how to complete and submit form are on page 2.

SECTION 1 - RECIPIENT INFORMATION		
Name of Recipient (last, first, middle)	Medicaid Case Number	Date of Birth (mm / dd / yyyy)
Last Residence (number and street, city, state, and ZIP code)		County
Date of Death (mm / dd / yyyy)	Date Remains Received (mm / dd / yyyy)	Date of Burial (mm / dd / yyyy)

SECTION 2 - FUNERAL / CEMETERY EXPENSES	
Claim Type - Funeral	Claim Type - Cemetery
Total Expenses $	Total Expenses $

SECTION 3 - CONTRIBUTIONS AND RESOURCES	
Claim Type - Funeral	Claim Type - Cemetery
Total Contributions $	Total Contributions $
Contributor Name(s)	Telephone Number (xxx-xxx-xxxx)

SECTION 4 - CLAIMANT AFFIRMATION STATEMENT		
Corporation Name of Funeral Home and/or Cemetery	Specific Name of Funeral Home and/or Cemetery	
Specific Funeral Home and/or Cemetery Street Address	City, State, Zip Code	
Funeral Home and/or Cemetery Federal Tax ID# (EIN)	Fax Number (xxx-xxx-xxxx)	Telephone Number (xxx-xxx-xxxx)
Amount Claimed Funeral $	Amount Claimed Cemetery $	Total Requested State Assistance
Pursuant to the provisions of IC 5-11-10-1(e), I certify that the foregoing account is true and correct, that the following amount requested is legally due, after allowing all just credits, and that no part of the same has been paid.		Amount Due $
Signature of Funeral Home / Cemetery Representative		Date Signed (mm / dd / yyyy)
Printed Name		Federal Tax Identification Number (EIN)

SECTION 5 - TO BE COMPLETED BY THE STATE						
Medicaid Effective Date (mm / dd / yyyy)	State Region Number					
Medicaid Category ☐ MA A	☐ MA D	☐ MA B	☐ MASI	☐ MADW	☐ MA R	
I hereby certify that this claim covering funeral and cemetery expenses is in proper form, that the deceased recipient on whose behalf payment is to be made has been found eligible for such services under the provisions of IC 12-14-17, and that this claim in the amount of the following amount is being recommended for payment.						
Claim Amount $						
Signature of DFR Representative				Date Signed (mm / dd / yyyy)		

INSTRUCTIONS FOR COMPLETING AND SUBMITTING STATE FORM 35937

PLEASE ONLY SUBMIT THIS FORM ONE TIME. SUBMITTING MULTIPLE CLAIMS MAY RESULT IN YOUR CLAIM BEING DENIED

SECTION 1 - RECIPIENT INFORMATION:

- Enter recipient's full name, Medicaid case number, and their date of birth. Enter recipient's last known residence; include county name.
- Enter the date of death, date claimant received the decedent's remains. If appropriate, the date of disposition / cremation or N/A.

SECTION 2 – FUNERAL / CEMETERY EXPENSES:

- Claim Type Funeral – Enter final total expenses (do not subtract any monies from contributions, resources, or discounts received or expected to receive).
- Claim Type Cemetery – Enter final total expenses (do not subtract any monies from contributions, resources or discounts received or expected to receive from the State).

SECTION 3 - CONTRIBUTIONS AND RESOURCES:

- Contributions – Enter total amount of monies received from family, friends, and estate resources (do not include discounts or amounts expected from the State).
- Each contributor's name and telephone number need to be reported. Attach additional pages if space is needed.

SECTION 4 - CLAIMANT AFFIRMATION STATEMENT:

- Enter Funeral Home / Cemetery name, Address, Funeral Homes current Federal Tax Identification Number, Fax number and Telephone number.
- Amount Claimed – Funeral: Enter the expected state assistance for funeral expenses.
- Amount Claimed – Cemetery: Enter the expected state assistance for cemetery expenses.
- Total expected state assistance: Add the totals for both funeral and cemetery expenses and enter that amount here. Fill in the total expected amount of State assistance on the line within the claimant Affirmation Statement.
- Funeral and / or Cemetery Provider signs form, including current Funeral Home and/or Funeral Director's Federal Tax Identification Number and enter date claim was signed.

SECTION 5 - TO BE COMPLETED BY THE STATE

- Leave blank; State completes this portion of the claim.

IMPORTANT INFORMATION:

- Decedent qualification inquiries: Call **1-800-403-0864; Option #7.**
- Report any additional monies received to Claimsinfo@fssa.in.gov within ninety (90) days of receipt. Additional monies received may result in a determination that the state overpaid and any overpayment will need to be reimbursed back to the State of Indiana.
- **A W-9 form must be on file with the FSSA Accounts Payable Office, or the claim will not be paid.**
- Submit claims by fax or e-mail to the Burial Assistance Office; see contact information below.
- More information can be found at www.in.gov/fssa/dfr/5277.htm.

CONTACT INFORMATION:

Burial Assistance Office at: **Telephone: 1-317-234-1412 Fax: 317-234-5075** **indianaburialclaims@fssa.in.gov** **FOR** Submitting a claim or reporting facility changes.	FSSA Accounts Payable at: **claimsInfo@fssa.in.gov** **FOR** Payment inquiries, submitting W-9 form, reporting overpayment, or submitting overpayment. NOT FOR SUBMITTING CLAIMS	Estate Recovery at: **estaterecovery@fssa.in.gov** **FOR** Inquiries on the recipient's estate, funeral trusts, prepaid funerals.