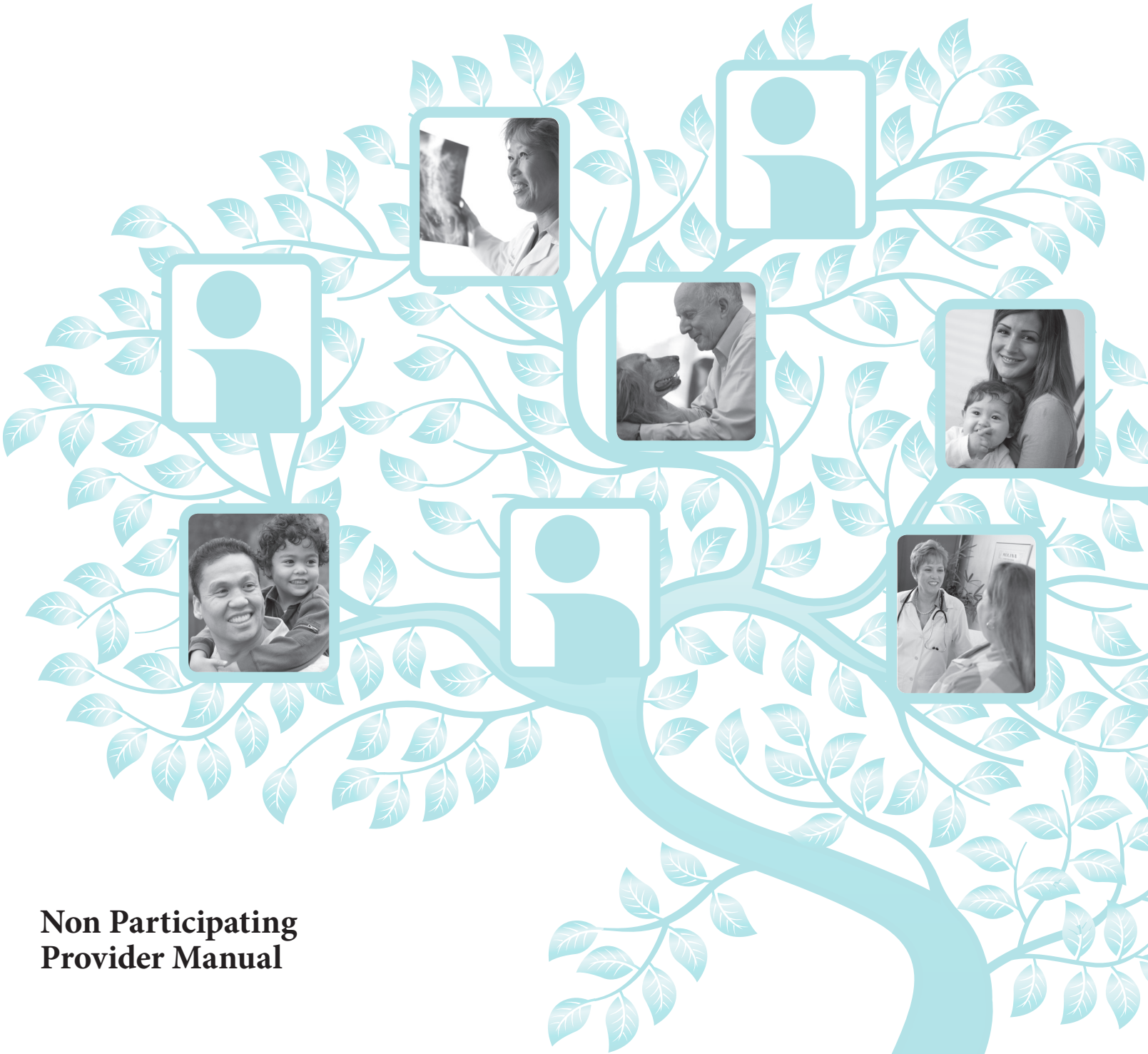
# Welcome to the Molina Family.



## Non Participating Provider Manual

MOLINA® HEALTHCARE

Your Extended Family.

Dear Provider,

Thank you for providing care for our Member. It is important for us to assist you with getting your claims processed promptly and in a timely manner. Please keep in mind:

- All out of network services must be preauthorized by Molina Healthcare
- Molina's ePortal is only available to participating providers

For your convenience we have included educational materials on how to submit your claims to Molina Healthcare.

In our efforts to provide ongoing network adequacy to our members we are constantly seeking qualified providers to assist in the delivery of health care throughout the state of Texas. If you are a Texas provider and qualify to participate in Medicaid and/or Medicare and would like to join our network of healthcare professionals, please complete the Contract Request Form at the end of this document.

Thank you for your commitment to join with Molina Healthcare in providing our members with the best quality healthcare possible.

Sincerely,

Cathy Rosado

Director of Enrollment Growth, Molina Healthcare of Texas

# Claims Guidelines

## Paper Claims Guidelines

Non-electronic claims must be submitted to Molina on a CMS 1500 or UB-04 claim form that is legible and accurate within ninety-five (95) days of the date of service. Molina is also able to accept the UB92. Non-electronic claims that meet the requirements of a clean claim as defined in Title 28 of the Texas Administrative Code Chapter 21 Subchapter T will be paid or denied within thirty (30) days of receipt. Claims that do not meet the clean claim requirements will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late payment penalties on claims that do not meet the requirements of a clean claim.

**Non-electronic claims should be mailed to:**

**Molina Healthcare**
**Attn: Claims**
**PO Box: 22719**
**Long Beach, CA 90801**

## Electronic Claims Submission Guidelines

Electronic claims must be submitted to Molina using the Professional 837 format within 95 days of the date of service. Electronic claims that meet the clean claim requirements as defined in Title 28 Texas Administrative Code Chapter 21 Subchapter T will be paid or denied within thirty (30) days of receipt. Molina shall pay Network Providers interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not paid within 30 days. Claims that do not meet the requirements of a clean claim will still be paid or denied in a timely manner where possible, but Molina will not be liable for any late-payment penalties on claims that do not meet the requirements of a clean claim.

Electronic claims can be sent to Molina via: www.Molinahealthcare.com

Additionally, Molina's accepts electronic claims through most major claims clearinghouses. Providers submitting claims electronically should use Payor ID 20554.

It is important to track your electronic transmissions using your acknowledgement reports. The reports assure claims are received for processing in a timely manner.

When your claims are filed electronically:

A. You should receive an acknowledgement from your current clearinghouse
B. You should receive an acknowledgement from WebMD within five to seven business days of your transmission
C. You should contact your local clearinghouse representative if you experience any problems with your transmission

**Note:** Molina will notify Network Providers in writing of any changes in the list of claims processing or adjudication entities at least thirty (30) days prior to the effective date of change. If Molina is unable to provide at least thirty (30) days notice, the Molina will give Network Providers a 30-day extension on their claims filing deadline to ensure claims are routed to correct processing centers.

## Coordination of Benefits and Third Party Claims

The following information pertains to COB/TPA billed claims:

Molina is secondary to all private insurance. Private insurance carriers and Medicare, must be billed prior to billing Molina, or medical groups/IPAs. The Provider must include a copy of the other insurance's explanation of benefits (EOB) with the claim. Molina will pay the difference between payment made by the primary insurance carrier and Molina's maximum contracted allowable rate. If the primary insurance paid more than Molina's maximum contracted allowable rate the claim will pay zero.

Molina will pay claims for covered services when probable TPL/COB has not been established or third party benefits are not available to pay a claim. Molina will attempt to recover any third-party resources available to Members and shall maintain records pertaining to TPL/COB collections on behalf of Members for audit and review.

## Physicians and Non-Institutional Providers

***Requirements for a Clean Claim***

Claims must be submitted on CMS 1500

**A clean claim relating to physicians or non-institutional providers is comprised of the following (Included are the appropriate CMS references to specific fields):**

1. Subscriber's/patient's plan ID number (CMS 1500, field 1a)
2. Patient's name (CMS 1500, field 2)
3. Patient's date of birth and gender (CMS 1500, field 3)
4. Subscriber's name (CMS 1500, field 4) is required, if shown on the patient's ID card
5. Patient' address (street or P.O. Box, city, state, zip) (CMS 1500, field 5) is required
6. Patient's relationship to subscriber (CMS 1500, field 6)
7. Subscriber's address (street or P.O. Box, city, state, zip) (CMS 1500, field 7) required but physician or provider may enter "same" if the subscriber's address is the same as the patient's address required by requirement "E"
8. Subscriber's policy number (CMS 1500, field 11)
9. HMO or insurance company name (CMS 1500, field 11c)
10. Disclosure of any other health benefit plans (11d)
11. Patients or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500, field 12)
12. Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (CMS 1500 field 13)
13. Date of injury (CMS 1500, field 14) is required, if due to an accident
14. Name of referring physician or other source (CMS 1500, field 17) is required for primary care physicians, specially physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None".
15. I.D. Number of referring physician (CMS 1500 field 17a) is required for primary care physicians, specialty physicians and hospitals; however, if there is no referral, the physician or provider shall enter "Self-referral" or "None".
16. Narrative description of procedure (CMS 1500, field 19) is required when a physician or provider uses an unlisted or not classified procedure code or an NDC code for drugs.
17. For diagnosis codes or nature of illness or injury (CMS 1500, field 21), up to four diagnosis codes may be entered, but at least one is required (Primary diagnosis must be entered first);

18. Verification number (CMS 1500, field 23), is required if services have been verified. If no verification has been provided, a prior authorization number (CMS 1500, field 23), is required when prior authorization is required and granted;
19. Date(s) of service (CMS 1500, field 24A)
20. Place of service codes (CMS 1500, field 24B)
21. Procedure/modifier code (CMS 1500, field 24 D)
22. Diagnosis code by specific service (CMS 1500, field 24E) is required with the first code linked to the applicable diagnosis code for that service in field 21
23. Charge for each listed service (CMS 1500, field 24F)
24. Number of days or units (CMS 1500, field 24G)
25. Rendering physician's or provider's Medicaid TPI number (CMS 1500, field 24, 12-90 version). For CMS 1500 08-05 version, rendering physician's or provider's NPI number in field 24J.
26. Whether assignment was accepted (CMS 1500, field 27), is required if assignment under Medicare has been accepted.
27. Total charge (CMS 1500, field 28)
28. Amount paid, (CMS 1500, field 29), is required if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber.
29. Signature of physician or provider or notation that the signature is on file with the HMO or preferred provider carrier (CMS 1500, field 31)
30. Name and address of facility where services rendered (if other than home or office) (CMS 1500, field 32,)
31. Physician's or provider's billing name, address and telephone number is required, and the provider number (CMS 1500, field 33, 12-90 version) is required if the HMO or preferred provider carrier required provider numbers and gave notice of that requirement to physicians and providers prior to June 17, 2003. For CMS 1500 08-05 version, physician's or provider's **billing** NPI number should be in field 33a.

Per the NUCC (National Uniform Claim Committee) the rendering provider NPI should be submitted in box 24J and the billing provider NPI in box 33A on the paper claim. Below is information regarding the appropriate fields for the rendering and billing provider NPIs. Please work with your billing representative to ensure that NPIs are correctly populated on electronic and paper claims. This will allow Molina to submit accurate claims data to the state agency per state requirements.

## Required NPI Fields

| CMS-1500 | Field Location | Required |
|---|---|---|
| Referring Provider | Box 17b | Requested* |
| Rendering Provider | Box 24j | **Required** |
| Facility | Box 32a | Requested* |
| Billing Provider | Box 33a | **Required** |
| LTSS Provider Only | **in 33b** | **Required** |

## Institutional Providers

Claims must be submitted on UB-04 form.

***Requirements for a Clean Claim***

**Required data elements for institutional providers are listed as follows:**

1. Provider's name, address and telephone number (UB-04, field 1)
2. Pay to Provider's name, address and telephone number (UB-04, field 2) Optional, use if pay to address is different from address in field 1.
3. Patient control number (UB-04, field 3)
4. Type of bill code (UB-04, field 4) is required and shall include a "7" in the third position if the claim is a corrected claim.
5. Provider's federal tax ID number (UB-04, field 5)
6. Statement period (beginning and ending date of claim period) (UB-04, field 6)
7. Covered days (UB-04, field 7), is required if Medicare is a primary or secondary payor
8. Patient's name (UB-04, field 8)
9. Patient's address (UB-04, field 9)
10. Patient's date of birth (UB-04, field 10)
11. Patient's gender (UB-04, field 11)
12. Date of admission (UB-04, field 12) is required for admissions, observation stays, and emergency room care
13. Admission hour (UB-04, field 13) is required for admissions, observation stays, and emergency room care
14. Type of admission (e.g., emergency, urgent, elective, newborn) (UB-04, field 14)
15. Source of admission code (UB-04, field 15)
16. Discharge hour (UB-04, field 16), required for admissions, outpatient surgeries or observation stays
17. Patient-status-at-discharge code (UB-04, field 17) is required for admissions, observation stays, and emergency room care
18. Condition codes (UB-04, fields 18-28), required if appropriate
19. Occurrence codes and all dates (UB-04, fields 31-34) required if appropriate
20. Occurrence span codes, from and through dates (UB-04, fields 35-36) required if appropriate
21. Value code and amounts (UB-04, field 39-41) required for inpatient admissions, If no value codes are applicable to the inpatient admission, the provider may enter value code 01
22. Revenue code (UB-04, field 42)
23. Revenue description (UB-04, field 43)

24. HCPCS/Rates (UB-04, field 44) required if Medicare is a primary or secondary payor
25. Service date (UB-04, field 45) required if the claim is for outpatient services
26. Units of service (UB-04, field 46)
27. Total charge (UB-04, field 47) not applicable for electronic billing
28. Non-Covered charge (UB-04, field 48) required if information is available and applicable
29. Payor identification (UB-04, field 50)
30. Health Plan identifier number (UB-04, field 51) required
31. Release of information indicator (UB-04, field 52) required.
32. Prior payments-payor and patient (UB-04, field 54) required if payments have been made to the physician or provider by the patient or another payor or subscriber, on behalf of the patient or subscriber.
33. Billing provider name and identifiers, including NPI (UB-04, field 56) required on all claims.
34. Other Provider ID (UB-04, field 57) Required, Texas providers should include their TPI in this field.
35. Insured's name (UB-04, field 58) is required if shown on the patient's ID card
36. Patient's relationship to insured (UB-04, field 59)
37. Insured's unique ID number (UB-04, field 60), required, shown on patient's ID card.
38. Insurance Group Name (UB-04, field 61) required if shown on patient's ID card.
39. Insurance group number (UB-04, field 62), required if shown on patient's ID card
40. Treatment authorization codes (UB-04, field 63) required if services have been authorized.
41. Diagnosis and procedure code qualifier (UB-04, field 66)
42. Principle diagnosis code (UB-04, field 67) Required on all claims
43. Diagnoses codes other than principal diagnosis code (UB-04, field 67A-Q), are required if there are diagnoses codes other than principal diagnosis.
44. Admitting diagnosis code (UB-04, field 69)
45. Patient's reason for visit (UB-04, field 70), required for unscheduled outpatient visits
46. Principal procedure code (UB-04, field 74) required if the patient has undergone an inpatient or outpatient surgical procedure
47. Other procedure codes (UB-04, fields 74A-E), are required as an extension of "46" if additional surgical procedures were performed
48. Attending physician name and identifiers, including NPI (UB-04, field 76) Required on all claims
49. Operating Physician name and identifier, including NPI (UB-04, field 77) Required only when surgical procedure on claim
50. Other providers name and identifiers, including NPI (UB-04, fields 78-79) Requested if information is available

## UB-04

Molina began accepting the new UB-04 on March 1, 2007. We are accepting institutional claims filed by facilities such as hospitals, skilled nursing facilities, hospices, and others, using either the UB92 or UB04. The new UB04 claim form may be obtained from the National Uniform Billing Committee web site at www.nubc.org.

Information regarding the revised form may also be found on the CMS website: http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5072.pdf.

## Molina Required/Requested NPI Fields

| UB04 | Field Location | |
|---|---|---|
| Billing Provider | Box 56 | **Required** |
| Attending Provider | Box 76 | Requested* |
| Operating Provider | Box 77 | Requested* |
| Other Provider | Boxes 78 & 79 | Requested* |

## Emergency Services Claims

If the claim is for emergency service(s), no authorization is required. If Molina has reasonable grounds for suspecting fraud, misrepresentation or unfair billing practices, then additional information from the provider may be requested.

## Claims Codes

Providers must use good faith effort to bill Molina Healthcare for services with the most current coding (ICD-9, CPT, HCPCS etc.) available. The following information must be included on every claim:

A. Member name, date of birth and ID number or PIC number
B. Date(s) of service
C. ICD-9 diagnosis and procedure codes
D. Revenue, CPT or HCPCS code for service or item provided
E. Billed charges for service provided
F. Place and type of service code
G. Days or units, as applicable
H. Provider tax identification and NPI number
I. Provider name and address

## Billing Members

Providers are not allowed to bill Molina Members for any amounts billed but not paid by Molina.

**It is important to note that there are no co-pays for Medicaid managed care members.**

***Member Acknowledgement Statement***

**A provider may bill the following to a Member without obtaining a signed Member Acknowledgment Statement:**

- Any service that is not a benefit under Molina's Program (for example, personal care items).
- The provider accepts the Member as a private pay patient. Providers must advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.

- The Member is accepted as a private pay patient pending Medicaid eligibility determination and does not become eligible for Medicaid retroactively. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

A provider attempting to bill or recover money from a Member in violation of the above conditions may be subject to exclusion from Molina.

In accordance with current federal policy, Members cannot be charged for the Member's failure to keep an appointment. Only billings for services provided are considered for payment. Members may not be billed for the completion of a claim form, even if it is a provider's office policy.

## Special Billing

***Newborns***

The following name conventions are to be used for newborns:

- If the mother's name is "Jane Jones," use "Boy Jane Jones" for a male child and "Girl Jane Jones" for a female child.
- Enter "Boy Jane" or "Girl Jane" in first name field and "Jones" in last name field. Always use "boy" or "girl" first and then the mother's full name. An exact match must be submitted for the claim to process.
- ***Do not*** use "NBM" for newborn male or "NBF" for newborn female.

***Private Pay Form Agreement***

A private pay form agreement allows for a reduction in payment by a provider to a Member due to a medically needy spend down (effective September 1, 2003, the MNP is limited to children younger than age 19 years and pregnant women). If a provider accepts a Member as a private pay patient, the Provider **must** advise Members that they are accepted as private pay patients at the time the service is provided and is responsible for paying for all services received. In this situation, HHSC strongly encourages the provider to ensure that the Member signs written notification so there is no question how the Member was accepted. Without written, signed documentation that the Medicaid Member has been properly notified of the private pay status, the provider does not seek payment from an eligible Medicaid Member.

There are instances in which the Member is accepted as a private pay patient and a provider may bill a member. This is acceptable, if the provider accepts the patient and informs the member at the time of service that they will be responsible for paying for all services. In this situation, it is recommended that the provider use a Private Pay Form. The provider is allowed to bill the Member as a private pay patient if retroactive eligibility is not granted. If the Member becomes eligible retroactively, the Member notifies the provider of the change in status. Ultimately, the provider is responsible for filing timely Medicaid claims. If the Member becomes eligible, the provider must refund any money paid by the Member and file Medicaid claims for all services rendered.

**SAMPLE**

# Private Pay Agreement Form

# Member Acknowledgment Statement

"I understand that, in the opinion of (provider's name), the services or items that I have requested to be provided to me on (dates of service) may not be covered under Molina Healthcare as being reasonable and medically necessary for my care. I understand that HHSC or its health insuring agent determines the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment of the services or items I request and receive if these services or items are determined not to be reasonable and medically necessary for my care."

"Comprendo que, según la opinión del (nombre del proveedor), es posible que Medicad no cubra los servicios o las provisiones que solicité (fecha del servicio) por no considerarlos razonables ni médicamente necesarios para mi salud. Comprendo que Molina Healthcare de Texas o su agente de seguros de salud determina la necesidad médica de los servicios o de las provisiones que el miembro solicite o reciba. También comprendo que tengo la responsabilidad de pagar los servicios o provisiones que solicité y que reciba si después se determina que esos servicios y provisiones no son razonables ni médicamente necesarios para mi salud."

_____

**Member Signature** **Date**

## Claims Questions, Re-Consideration and Appeals

Additional details regarding the process and timelines to appeal claim payments can be found in the "Complaints and Appeals" Chapter of this manual (chapter 10).

If a provider has a question or is not satisfied with the information or payment they have received related to a claim, they should contact Customer Services at 866-449-6849.

**How to file a claims determination appeal:**

An appeal must be filed in writing. If you do not agree with the claims determination, then:

- Submit a written letter of appeal detailing the reason for appeal along with supporting documentation within 120 days of your original claims determination.
- Mail or Fax your appeal to:

**Write to:**

Molina Healthcare
Attn: Appeals
15115 Park Row Blvd Ste 110
Houston, TX 77084
**FAX # 877-319-6852**

# Molina Healthcare

## Provider Quick Reference Guide | IMPORTANT NUMBERS

### APPEALS ADDRESS
**15115 Park Row Blvd. Suite # 110**
**Houston, Texas 77084**
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas ..... 866-449-6849
CHIP Rural Service Area ..... 877-319-6826

### BEHAVIORAL HEALTH SERVICES
..... 800-818-5837
BH Fax for Prior Authorization ..... 866-617-4967
For Behavioral Health Services in Dallas Service Area
(STAR & STAR+PLUS), please call NorthSTAR at ..... 888-800-6799

### CONTRACTING
texasexpansioncontracting@molinahealthcare.com
- How to join the network
- Contract Clarifications
- Fee schedule inquires

### CUSTOMER SERVICE (MEMBERS AND PROVIDERS)
- Claims Status
- Member Eligibility
- Benefit Verification
- Complaint & Appeals Status

Bexar, Harris, Dallas, Jefferson, El Paso &
Hidalgo Service Areas (Voice) ..... 866-449-6849
..... (Fax) 281-599-8916
CHIP Rural Service Area ..... (Voice) 877-319-6826
..... (Fax) 281-599-8916

### DENTAL SERVICES
Delta Dental Insurance Company ..... 866-561-5891
Denta Quest ..... 800-508-6775
MCNA Dental ..... 800-494-6262

### ELECTRONIC CLAIMS SUBMISSION VENDORS
- Payor Identification for all - 20554
- Availity, Zirmed, Practice Insight, SSI & EMDEON

### MEDICAL MANAGEMENT
- Prior Notification
- Prior Authorization
- Referrals
- Disease Management

STAR+PLUS Service
Coordination Department ..... (Voice) 866-409-0039
..... (Fax) 866-420-3639

### MOLINA COMPLAINTS ADDRESS
**N.E. Loop 410, #200,**
**San Antonio, TX 78216**
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas ..... 866-449-6849
CHIP Rural Service Area ..... 877-319-6826

### NURSE ADVICE LINE
- Clinical Support for Members

..... 888-275-8750 (English) or
..... 866-648-3537 (Spanish)

### PAPER & CORRECTED CLAIMS ADDRESS
**P.O. Box 22719**
**Long Beach, CA 90801**

### PHARMACY
Prior Authorization
Assistance/Inquiries
..... (Voice) 866-449-6849
..... (Fax) 888-487-9251

### PROVIDER SERVICES
Bexar, Harris, Dallas, Jefferson,
El Paso & Hidalgo Service Areas ..... 866-449-6849
CHIP Rural Service Area ..... 877-319-6826

### STAR+PLUS SERVICE COORDINATION
..... 866-409-0039
..... (Fax) 866-420-3639

### VISION SERVICES:
(www.opticarevisionplans.com;
provrel@opticare.net)
..... 800-537-6697 (CHIP)
..... 866-492-9711 (STAR)
..... 877-832-4118 (STAR+PLUS)

## MEDICAID CONTACTS

### CHIP ELIGIBILITY ..... 800-645-7164
### CHIP MEMBER ENROLLMENT ..... 800-647-6558
### EARLY CHILDHOOD INTERVENTION ..... 800-628-5115
### EPORTAL TECHNICAL SUPPORT ..... 866-449-6848
### FAMILY PLANNING PROGRAM ..... 512-458-7796
### MEDICAL TRANSPORTATION PROGRAM (MTP)
STAR & STAR+PLUS ..... 877-633-8747
### MEDICAID HOTLINE ..... 800-252-8263
### MEDICAID PROGRAM MEMBER
Verification (NAIS) ..... 800-925-9126
### NPI # REQUEST
https://nppes.cms.hhs.gov ..... 800-925-9126
### STARLINK-MEDICAID MANAGED CARE HELPLINE
General Member Assistance ..... 866-566-8989
### STAR & STAR+PLUS PROGRAM ENROLLMENT
PCP Information
Plan Changes
Health Plan Information ..... 800-964-2777
### TEXAS HEALTH STEPS
STAR & STAR+PLUS ..... 877-847-8377
### TEXAS DEPARTMENT OF INSURANCE
HMO Division ..... 512-322-4266
HMO Complaint ..... 512-305-6745
Consumer Division ..... 512-463-6500
Consumer Hotline ..... 800-525-3439

### TEXAS VACCINES FOR CHILDREN PROGRAM ..... 800-252-9152



**Please visit www.MolinaHealthcare.com**

MOLINA® HEALTHCARE

# *Contract Request Form (CRF)*

(please print legibly)

**Note to Provider:** In an effort to generate the proper contract and credentialing packet, please complete this contract request form and fax back to: 877-319-6851
Attn: Contracting Team or email form to: mhtcontracting@molinahealthcare.com.

Requestor Name: _____ Email: _____

*Provider Name: _____ *Group Name: _____

*Specialty: _____ *Tax ID: _____

**Physical Address: _____ *Mailing Address: _____
(**Note: Physical Address where members are to be seen)

City, State, Zip: _____ *City, State, Zip: _____

*Office Phone: _____ * Group Phone: _____

*Office Fax: _____ *Group Fax: _____

*Ind TPI: _____ *Group TPI: _____
(if TPI number is not attested- we are unable to contract for Medicaid) (if TPI number is not attested - we are unable to contract for Medicaid)

*Ind NPI: _____ *Group NPI: _____
(if NPI number is not attested- we are unable to contract for Medicaid) (if no valid NPI number - we are unable to contract for Medicaid)

*Ind Medicare: _____ *Group Medicare: _____
(if no valid Medicare number - we are unable to contract for Medicare) (if no valid Medicare number - we are unable to contract for Medicare)

☐ **STAR** ☐ **CHIP** ☐ **CHIP Perinate** ☐ **STAR+PLUS** ☐ **Medicare Options** ☐ **Medicare Options +**

Mail contract packet to (if different from above): _____

Date requested: _____ (please allow 7-10 business days for packet to be mailed out)

| **For Office Use Only** | | |
|---|---|---|
| Rep Name: | | Rep Comments: |
| THSteps TPI: | | Date Mailed out: |
| Grp. THSteps: | | Notes: |
| Current Status: | | |
| **Cactus** | Credentialed: Y N<br>Delegated: Y N | |
| **QNXT** | Loaded: Y N<br>PAR: Y N | |
| **MPF** | Verified: Y N<br>Specialty:_____ | |
| **PC Tracker** | Loaded: Y N | |
| **Packet Type** | PSA HDO (circle one) | |
| Verified by: | | Date: |

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Your Extended Family.