THIRD PARTY LIABILITY (TPL) DISCREPANCY FORM

This form is to be used for all TPL discrepancy requests. Requests should be sent to **cbh.tpl.discrepancy@phila.gov**.

Provider Information

Facility Contact Person:	
Contact Phone Number:	
Parent Number:	

Member and Claim Information

Member Name:	
Member Address:	
Member Date of Birth:	
Member Social Security #:	
Date of Service:	
CIS Number:	
Level of Care (LOC):	
BAN/Authorization #:	

Insurance Information

Insurance Carrier Name:	
Policy #:	
Insurance Carrier Phone #:	
Reason(s) for TPL Discrepancy:	

CBH Results and Comments

TPL Active:	☐ **Yes** ☐ **No**
Effective Date:	
Termination Date:	
CBH Comments:	

*Please format all dates as **MM/DD/YYYY**.*