



MEDICAID RECIPIENT CLAIM TO DEFRAY BURIAL COSTS

State Form 35937 (R5 / 2-20)
Approved by State Board of Accounts, 2020

Claimant must complete, sign and date form. Submit to Family and Social Services Administration (FSSA), Division Family Resources (DRF), 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)	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 cost \$	Total cost \$	
SECTION 3 – CONTRIBUTIONS AND RESOURCES		
Claim Type - Funeral	Claim Type - Cemetery	
Total contributions \$	Total contributions \$	
Contributor name(s) for each	Telephone number ()	
SECTION 4 – CLAIMANT AFFIRMATION STATEMENT		
Name of funeral home and/or cemetery	Fax number ()	Telephone number ()
Amount claimed – funeral \$	Amount claimed – cemetery \$	Total requested State assistance \$
Pursuant to the provision of IC 5-11-10-1(e), I certify that the foregoing account is true and correct, that the amount requested () is legally due, after allowing all just credits, and that no part of the same has been paid.		
Signature funeral home / cemetery		Date signed (mm/dd/yyyy)
Printed name		Federal identification number

SECTION 5 – TO BE COMPLETED BY THE STATE	
Medicaid effective date (mm/dd/yyyy)	Region number
Medicaid Category <input type="checkbox"/> MA A <input type="checkbox"/> MA D <input type="checkbox"/> MA B <input type="checkbox"/> MASI <input type="checkbox"/> MADW <input type="checkbox"/> MA R	
I hereby certify that this claim covering burial expenses is in proper form; that the deceased recipient in 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 \$ _____ is being recommended for payment.	
Signature of DFR representative	Date signed (mm/dd/yyyy)
Printed name	Title

INSTRUCTONS FOR COMPLETING AND SUBMITTING STATE FORM 35937

SECTION 1 – Recipient Information:

- Enter recipient's full name, 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 / Burial Expenses:

- Claim Type Funeral – Enter final total expenses (do not subtract any monies from contributions, resources or discounts received or expect to receive the State).
- Claim Type Cemetery – Enter final total expenses (do not subtract any monies from contributions, resources or discounts received or expect 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 given discounts or amount expected from the State).
- Each contributor name and telephone number needs to be reported. Attach additional pages if space is needed.

Section 4 – Claimant Affirmation Statement:

- Enter Funeral Home / Cemetery name, Fax number and Telephone number. Address is not needed.
- 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 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, include current Federal identification number and enter date claim was signed

Section 5 – State Section:

- Leave blank; State completes this portion of the claim

Important Information:

- Decedent qualification inquiries: Call 1-800-403-0864; select the appropriate prompts.
- 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 overpayments will need to be reimbursed back to the State.
- A claim will not be processed unless a Provider Agreement is on file with the DFR.
- A W-9 form must be on file with the FSSA Accounts Payable Office or the claim will not be paid.
- Submit claims by either 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, Provider Agreement, or reporting facility changes

FSSA Accounts Payable at:
ClaimsInfo@fssa.in.gov
FOR
Payment inquiries, submitting W-9 form, reporting overpayments, or submitting overpayments

Estate Recovery at:
Estaterecovery@fssa.in.gov
FOR
Inquiries on the recipient's estate, funeral trusts, prepaid funerals