

EXHIBIT 7.2
Third Party Resources Information Sheet

NEW	CHANGE
1. CLIENT NAME:	2. CLIENT ID NUMBER:
3. INSURANCE COMPANY NAME:	4. INSURANCE COMPANY ADDRESS:
5. TYPE OF COVERAGE: <input type="checkbox"/> Major Medical <input type="checkbox"/> Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Surgical <input type="checkbox"/> Other	6. PERSON CARRYING THE POLICY:
7. START DATE (MM/DD/YY):	8. END DATE (MM/DD/YY):
9. POLICY NUMBER:	10. GROUP NUMBER
11. RELATIONSHIP OF CLIENT TO CASE HEAD: <input type="checkbox"/> Self (1) <input type="checkbox"/> Absent Parent (2) <input type="checkbox"/> Other (3) <input type="checkbox"/> Parent (4) <input type="checkbox"/> Spouse (5) <input type="checkbox"/> Brother/Sister (6) <input type="checkbox"/> Uncle/Aunt (7) <input type="checkbox"/> Grandparent (8) <input type="checkbox"/> Legal Guardian (9)	
12. NAME OF PROVIDER:	
13. COMPLETED BY:	14. DATE SUBMITTED:

RETURN TO
ACS
P.O. BOX 667
CHEYENNE, WYOMING
82003-0667
FAX: (307) 772-8405

ACS USE ONLY

AUTHORIZED BY: _____ DATE: _____

INPUT BY: _____ DATE: _____