

THIRD PARTY LIABILITY CASUALTY INSURANCE INFORMATION

| | | | | | |
|--------------------|--------|-------|------------------------------------|------|-------|
| 1. DHS Case Name | | | 2. Date | | |
| 3. DHS Case Number | 4. Co. | Dist. | Sec. | Unit | Spec. |
| 5. Specialist Name | | | 6. Specialist Phone No. () | | |

INSTRUCTIONS:

- Please PRINT or TYPE
- Retain a COPY in DHS Case File

Mail ORIGINAL to:

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
THIRD PARTY LIABILITY DIVISION
BUREAU OF FINANCIAL MANAGEMENT
PO BOX 30479
LANSING MI 48909**

FAX: (517) 346-9817

E-MAIL: TPL_Health@Michigan.Gov

- This form and other information are also available through the internet at:
www.michigan.gov/mdch/1,1607,7-132-2945_5100-20412--,00.html
(Access this link by visiting www.michigan.gov/mdch , click on Providers, Information For Medicaid Policy, Third Party Liability)

Section 1 - RECIPIENT INFORMATION:

| 7. RECIPIENT NAME (Last, First, Middle) <i>Use Additional Sheets if Necessary</i> | 8. DATE OF BIRTH | 9. RECIPIENT I.D. NUMBER | 10. INJURY RELATED TO: (Check ONE) | | |
|--|---------------------------|--------------------------------|---|--------------------------|--------------------------|
| | | | WORK | MOTOR VEHICLE | OTHER |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Section 2 - WORK RELATED ILLNESS OR INJURY:

| | | | | |
|----------------------------|-----------------------------------|---|---------|-----------------------------------|
| 11. Date of Injury | 12. Claim Number | 16. Name of Employer at Time of Illness or Injury | | |
| 13. Insurance Company Name | | 17. Employer Address (No. & Street) | | 18. Employer Phone No. () |
| 14. Insurance Co. CITY | 15. Ins. Co. PHONE No. () | 19. City | 20. St. | 21. ZIP Code |

Section 3 - MOTOR VEHICLE ACCIDENT:

| | | | | |
|------------------------------------|--|---|--|--|
| 22. Date of Accident | 23. Policy or Claim No. | 27. DETERMINE and then CHECK the highest priority of Vehicle Insurance as Numbered Below. | | |
| 24. Vehicle Insurance Company Name | | <input type="checkbox"/> 1 - RECIPIENT <input type="checkbox"/> 3 - OWNER of Vehicle <input type="checkbox"/> 2 - Relative in Household <input type="checkbox"/> 4 - DRIVER of Vehicle | | |
| 25. Insurance Co. CITY | 26. Insurance Co. PHONE No. () | 28. Name of Insured Person | | |

Section 4 - OTHER ACCIDENT OR INJURY:

| | | | | |
|---|---|---|---------|--------------|
| 29. Date of Accident | 30. Policy or Claim No. | 34. Name of Insurance Company Covering Person or Premises | | |
| 31. Person who Caused Accident or Who Owns the Premises | | 35. Insurance Co. Address (No. & Street) | | |
| 32. Person / Owner CITY | 33. Person / Owner PHONE No. () | 19. City | 20. St. | 21. ZIP Code |
| 39. Briefly Describe What Happened: | | | | |

The Above Information is Correct and Complete to the Best of my Knowledge:

| | | | |
|---------------|---------------|------------------------|------|
| 40. Signature | 41. Phone No. | 42. Worker's Signature | Date |
|---------------|---------------|------------------------|------|