

Date:

FirstName LastName
Street Address
City, State Zip

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656).
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)
إذا كان لديكم أي سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

Date of service(s):

MIHealth Card ID #:

The Michigan Department of Community Health's records show that Medicaid has recently paid for medical services for you that may be related to an accident or injury. The Michigan Department of Community Health needs to gather additional information about these medical services and to determine whether there may be other insurance that may pay for these services. Please complete the requested information listed below and return this information within 14 days. Your cooperation in providing this information is a condition of Medicaid eligibility.

Michigan Department of Community Health
Questionnaire

INSTRUCTIONS:

- Please answer the questions on the opposite page as completely as you can and return the form in the envelope provided.
- Failure to respond may affect your Medicaid eligibility. Use additional sheets as needed.
- If you have questions about this form, contact our office at **Staff Phone**.

General Information:

1. Type of Accident: <input type="checkbox"/> Auto or Vehicle Related <input type="checkbox"/> Work Related <input type="checkbox"/> Other		2. Exact Date of Accident
3. Describe Your Accident:		
4. Name of Place Where Accident Happened		
5. Location of Accident (Number, Street, City, County, State)		
6. Briefly Describe the Injuries from this Accident		
7. Are You or Will You Be Represented by an Attorney? → <input type="checkbox"/> NO <input type="checkbox"/> YES →	8. Attorney's Name 10. Attorney's Address	9. Attorney's Phone Number ()

If this is an AUTO or VEHICLE related injury, please complete this section:

11. Were you a: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other:		
12. Did You or a Relative in Your Home Have Vehicle Insurance on the Date of the Accident? <input type="checkbox"/> NO <input type="checkbox"/> MYSELF <input type="checkbox"/> RELATIVE →	13. Name of Relative IN YOUR HOME Who Had Vehicle Insurance	14. Relationship to You (e.g. Uncle, cousin, etc.)
15. Name of Your and/or Your Relative's Vehicle Insurance Company / Agent	16. Policy Number	17. Ins. Co. Phone Number ()
18. Vehicle Insurance Company Complete Address (No. & Street, City, State, ZIP Code)		
19. Have You Filed an Automobile Insurance Claim? <input type="checkbox"/> NO <input type="checkbox"/> YES →	20. Claim Number	

If this is a WORK Related or Other Type of Injury, please complete this section:

21. Name of Employer, Property Owner or Other Responsible Person		22. Phone Number ()
23. Complete Address of Employer, Property Owner of Responsible Person (No. & Street, City, State, ZIP Code)		
24. Name of Insurance Company of Employer, Property Owner, or Responsible Person	25. Policy or Claim Number	26. Ins. Co. Phone Number ()
27. Insurance Company Complete Address (No. & Street, City, State, ZIP Code)		

I Certify that the Above Information is True and Complete to the Best of My Knowledge:

28. Signature of Person Completing This Form	29. Phone Number Where You Can be Reached During the Day ()
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