



**THIRD PARTY LIABILITY  
ACCIDENT/INJURY QUESTIONNAIRE**

Date: \_\_\_\_\_

Please complete all fields on the form below and return to the following address, facsimile, or e-mail:

Indiana Health Coverage Programs/HP Enterprise Services  
Third Party Liability Department  
P.O. Box 7262  
Indianapolis, IN 46207-7262

Fax: (317) 488 5217  
E-mail: INXIXTPLRequests@hp.com  
Questions, please call: 1-800-457-4510 or (317) 488-5046

**SECTION 1**

Medicaid member name \_\_\_\_\_ Medicaid RID \_\_\_\_\_  
Social Security number \_\_\_\_\_ Date of birth \_\_\_\_\_  
Date of accident/injury \_\_\_\_\_ Accident location \_\_\_\_\_

Does the member have other medical coverage?  Yes  No If yes, please complete the following information:

Policyholder name \_\_\_\_\_ Policyholder Social Security number \_\_\_\_\_

Policy number \_\_\_\_\_ Group name \_\_\_\_\_ Group number \_\_\_\_\_

Insurance carrier name \_\_\_\_\_ Insurance carrier phone number ( ) \_\_\_\_\_

Insurance carrier's complete address \_\_\_\_\_

Medical care release date: \_\_\_\_\_

Did the accident occurred in: (Check the appropriate box)

- Automobile  Member residence  Different residence  Work  Public place  
 School  Defective product  Medical malpractice  Other

List in detail the type of injuries that the Medicaid member sustained:

\_\_\_\_\_  
\_\_\_\_\_

Did any other family members sustain injury?  Yes  No If yes, are they Medicaid members?  Yes  No

If yes, please list the family member's complete name and Medicaid RID number:

\_\_\_\_\_  
\_\_\_\_\_

Describe in detail how the accident/injury occurred. If additional room is needed, please continue on a separate sheet of paper and attach to the questionnaire. (If applicable, include a copy of the police report.)

\_\_\_\_\_  
\_\_\_\_\_

Did the member hire an attorney?  Yes  No

Attorney name \_\_\_\_\_ Attorney's firm name \_\_\_\_\_

Attorney's complete address \_\_\_\_\_

Attorney's telephone number ( ) \_\_\_\_\_ Attorney's facsimile number ( ) \_\_\_\_\_

Did a settlement occur?  Yes  No Settlement amount \$ \_\_\_\_\_

Did the case get filed in court?  Yes  No

If yes, please provide the complete name and address of the court:

(Continued)

## Section 2

Is this accident/injury related to a motor vehicle accident? (If no, proceed to Section 3.)  Yes  No  
Did this accident involve more than one vehicle?  Yes  No  
Who is at fault in the motor vehicle accident?  Driver 1  Driver 2  
Did the person at fault accept liability?  Yes  No

**Driver 1:** Complete name \_\_\_\_\_

Complete address \_\_\_\_\_

Automobile insurance carrier name \_\_\_\_\_

Automobile insurance carrier address \_\_\_\_\_

Carrier telephone number ( ) \_\_\_\_\_ Policyholder's complete name \_\_\_\_\_

Policy number \_\_\_\_\_ Claim number \_\_\_\_\_

Claim adjuster's complete name \_\_\_\_\_ Adjuster's phone number ( ) \_\_\_\_\_

Did Driver 1 obtain an attorney?  Yes  No Attorney's name \_\_\_\_\_

Attorney's phone number ( ) \_\_\_\_\_ Attorney's facsimile number ( ) \_\_\_\_\_

Attorney's complete address \_\_\_\_\_

Attorney's firm name \_\_\_\_\_

**Driver 2:** Complete name \_\_\_\_\_

Complete address \_\_\_\_\_

Automobile insurance carrier name \_\_\_\_\_

Automobile insurance carrier address \_\_\_\_\_

Carrier telephone number ( ) \_\_\_\_\_ Policyholder's complete name \_\_\_\_\_

Policy number \_\_\_\_\_ Claim number \_\_\_\_\_

Claim adjuster's complete name \_\_\_\_\_ Adjuster's telephone number ( ) \_\_\_\_\_

Did Driver 2 obtain an attorney?  Yes  No Attorney's name \_\_\_\_\_

Attorney's phone number ( ) \_\_\_\_\_ Attorney's facsimile number ( ) \_\_\_\_\_

Attorney's complete address \_\_\_\_\_

Attorney's firm name \_\_\_\_\_

## SECTION 3

Did this accident or injury involve another person(s)?  Yes  No Has liability been accepted?  Yes  No

Did this accident or injury involve a business? (such as work or public place)  Yes  No Has liability been accepted?  Yes  No

If work related, did the case get filed with the Industrial Board?  Yes  No Date of filing: \_\_\_\_\_

Third party's complete name \_\_\_\_\_

Third party's complete address \_\_\_\_\_

Third party's complete phone number ( ) \_\_\_\_\_ Complete name of insurance carrier \_\_\_\_\_

Insurance carrier address \_\_\_\_\_

Insurance carrier telephone number ( ) \_\_\_\_\_ Policyholder complete name \_\_\_\_\_

Claim adjuster's complete name \_\_\_\_\_ Adjuster's telephone number ( ) \_\_\_\_\_

Did the third party obtain an attorney?  Yes  No Attorney's name \_\_\_\_\_

Attorney's complete address \_\_\_\_\_

Attorney's phone number ( ) \_\_\_\_\_ Attorney's facsimile number ( ) \_\_\_\_\_

Attorney's firm name \_\_\_\_\_