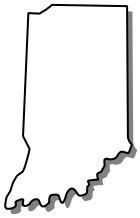
Indiana Health Coverage Programs



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