THIRD PARTY REPORTING FORM

Recipient ID (Medicaid #):_____

Recipient Name:_____

Insurance Company and Address:_____

_____

_____

Policy Number:_____

Group Number:_____

Effective Dates:_____

Subscriber:_____

Employer Name and Address:_____

_____

_____

Name/Address/Phone number of Person Completing Form:_____

_____

_____

Forward To:

TPL Unit/Fiscal and Accounting
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

DMAS-1001