THIRD PARTY LIABILITY INFORMATION

Please complete this form and return it to the address Listed below.

TREATED RECIPIENT'S NAME_____
LAST FIRST MIDDLE INITIAL

MEDICAID NUMBER OF TREATED RECIPIENT_____

DATE OF ACCIDENT OR INJURY_____TYPE OF ACCIDENT OR INJURY_____
(WORK,AUTO,HOME,FALL,GUNSHOT,ETC.)

If you have an attorney representing you for your accident or injury please complete the following:

NAME OF RECIPIENT'S ATTORNEY_____

NAILING ADDRESS OF ATTORNEY_____

If you do not have an attorney complete the following:

NAME OF INSURANCE COMPANY_____

ADDRESS OF INSURANCE COMPANY_____

POLICY NUMBER_____CLAIM NUMBER_____

If an auto accident complete the following:

NAME AND ADDRESS OF THE OWNER OF THE AUTO_____

NAME AND ADDRESS OF THE DRIVE OF THE AUTO_____

For other types of accidents complete the following:

LOCATION OF YOUR ACCIDENT_____

FURTHER COMMENTS_____

COMPLETED BY _____

PLEASE MAIL TO:

Third Party Liability Unit
Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, Virginia 23219

DMAS – 999 R9/87