



MEDICAID THIRD-PARTY LIABILITY ACCIDENT/INJURY QUESTIONNAIRE

Date:

Please complete all fields on the form below and submit it to the following mailing or email address or fax number:

IHCP Third-Party Liability
P.O. Box 7262 Indianapolis,
IN 46207-7262

Fax: 866-667-6579
 Email: INXIXTPLRequests@gainwelltechnologies.com
 Questions, please call: 800-457-4584

SECTION 1

Medicaid member name		Medicaid Member ID (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 telephone number	
Insurance carrier's complete address			
Medical care release date:			
Location of accident: <i>(Check the appropriate box)</i>		Type of accident: <i>(Check the appropriate box)</i>	
Member's residence	School	Public place/street	Automobile
Different residence	Workplace	Other	Medical malpractice
			Slip and fall
			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, list the family member's complete name and Medicaid Member ID (RID):			
Name:			Member ID:
Name:			Member ID:
Name:			Member ID:
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's name		Name of attorney's firm	
Attorney's complete address			
Attorney's telephone number		Attorney's fax 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 – Complete for Automobile Accident

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:

Driver's complete name					
Driver's 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 1 obtain an attorney?	Yes	No	Attorney's name		
Attorney's telephone number			Attorney's fax number		
Attorney's complete address					
Name of attorney's firm					

Driver 2:

Driver's complete name					
Driver's 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 telephone number			Attorney's fax number		
Attorney's complete address					
Name of attorney's firm					

SECTION 3 – Complete for All Other Accidents

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, was the claim filed with the Worker's Compensation Board?	Yes	No	Date of filing:		
Names of other parties (individuals or businesses) involved in the accident					
Other party's complete address					
Other party's telephone number			Insurance carrier name		
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 telephone number			Attorney's fax number		
Name of attorney's firm					