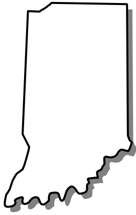

THIRD PARTY LIABILITY ACCIDENT/INJURY QUESTIONNAIRE

Date:

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

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

Fax: 1-866-667-6579
E-mail: INXIXTPLRequests@dxc.com
Questions, please call: 1-800-457-4584

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 occur 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 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

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 telephone number ( ) ______

Did Driver 1 obtain an attorney? ☐ Yes ☐ No Attorney's name ______

Attorney's phone number ( ) ______ Attorney's fax 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 fax 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 fax number ( ) ______

Attorney's firm name