Indiana Health Coverage Programs

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

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: *(Check the appropriate box)*
☐ Member's residence ☐ School ☐ Public place/street
☐ Different residence ☐ Workplace ☐ Other

Type of accident: *(Check the appropriate box)*
☐ Automobile ☐ 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			