THIRD PARTY LIABILITY ACCIDENT INFORMATION FORM

BENEFICIARY'S NAME	
DATE OF BIRTH	
BENEFICIARY'S MEDICAID ID# (IF KNOWN)	
BENEFICIARY'S SOCIAL SECURITY NO.	
COUNTY OF RESIDENCE	
DATE OF ACCIDENT	
INJURY SUSTAINED	
LAST DATE OF TREATMENT	
TYPE OF ACCIDENT	☐ Auto ☐ Medical ☐ Home ☐ Malpractice ☐ School ☐ Product Liability ☐ Work ☐ Other
INSURED RESPONSIBLE FOR ACCIDENT	
POLICY/CLAIM NO.	
INSURANCE COMPANY OR AGENT	
MAILING ADDRESS	
PHONE NO.	
FAX NO.	
BENEFICIARY'S ATTORNEY	
MAILING ADDRESS	
PHONE NO.	
FAX NO.	
COMMENTS:	
SUBMITTED BY:	
TITLE:	
DATE	TELEPHONE NO.

Mail Original to: Division of Health Benefits (Medicaid)

Third Party Liability 2508 Mail Service Center Raleigh, NC 27699-2508 Telephone No.: (919) 527-7690