THIRD PARTY RECOVERY ACCIDENT INFORMATION FORM

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

Mail Original To: **North Carolina Department of Health and Human Services**
Division of Medical Assistance/Third Party Recovery Section
2508 Mail Services Center
Raleigh, NC 27699-2508
Telephone No.: (919) 814-0240

DMA 2043
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