THIRD PARTY LIABILITY ACCIDENT INFORMATION FORM

Instructions for the Accident Information Reporting Form are on the back of the DHB-2043

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

INSTRUCTIONS FOR ACCIDENT INFORMATION REPORTING ON DHB-2043 FORM

PLEASE MAIL COMPLETED FORM TO:

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
THIRD PARTY RECOVERY SECTION
DIVISION OF HEALTH BENEFITS
2508 MAIL SERVICE CENTER
RALEIGH, NC 27699-2508

OR

YOU MAY FAX YOUR REPORT TO (919) 831-1812

Accurate completion of this form (including attorney/insurance company's address, telephone and fax number, date of accident, service dates, and release date) provides us with helpful information.