REQUEST FOR MEDICAID PAYMENT INFORMATION

RECIPIENT'S NAME:	
DATE OF BIRTH:	
RECIPIENT'S MEDICAID ID# (IF KNOWN):	
RECIPIENT'S 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**
ATTORNEY OR INSURANCE COMPANY:	
CONTACT PERSON:	
MAILING ADDRESS:	
PHONE NUMBER:	
FAX NUMBER:	
NAME OF INSURED (POLICYHOLDER):	
POLICY/CLAIM NO:	
RECIPIENT'S MEDICAL PAYMENTS INSURANCE:	
INSURANCE ADJUSTER:	
NAME OF INSURED (POLICYHOLDER):	
POLICY/CLAIM NO:	
ADDITIONAL INFORMATION:	