

To:  Department of Health Care Services  
TPL/Personal Injury Unit  
Fax: (916) 440-5668

OR

Health Management Systems  
WC Recovery Program  
660 J Street, Suite 270  
Sacramento, CA 95814

Date: \_\_\_\_\_

Mail: Original  
File: Copy

### POTENTIAL THIRD PARTY LIABILITY NOTIFICATION

1. Have you used, **or will you use**, Medi-Cal for your injury or illness? .....  Yes  No
2. Have you filed, **or will you file**, a lawsuit or insurance claim? .....  Yes  No

*If you answered Yes to one or both of the above questions, complete the following:*

3. Injury/illness occurred at:  Home  School  On someone else's property  
 Work  Motor vehicle  Other \_\_\_\_\_

Case name (first, middle, last)			Date of injury or illness (DATE MUST BE PROVIDED.)	
Address (number, street)	City	State	ZIP code	Social security number - -
Mailing address	City	State	ZIP code	Telephone number ( )

#### Injured Person(s):

Name	Date of Birth	County Code	Aid Code	Social Security Number (If not available, Medi-Cal or CIN)

4. Have you filed, **or will you file**, a lawsuit?  Yes  No If yes, please provide the following information:

Attorney name			Telephone number ( )	
Mailing address	City	State	ZIP code	

5. Is there insurance (other than Medi-Cal/Medicare) **covering you or anyone else** for this injury/illness (auto, homeowners, premise liability, accident, health)?  Yes  No If yes, please provide the following information:

Insurance company			Telephone number ( )	
Mailing address	City	State	ZIP code	
Claim adjuster	Claim/policy number	Policy holder		

#### WORK RELATED INJURY

- Have you filed an application for Workers' Compensation benefits?  Yes  No

Employer at time of accident		Telephone number ( )		Workers' Compensation claim/case number	
Mailing address	City	State	ZIP code		

**DO NOT WRITE BELOW THIS LINE**

#### COUNTY USE ONLY

Eligibility worker	Worker number	County	Telephone number ( )
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