STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
14/744 P STREET
O. BOX 942732
SACRAMENTO, CA 94234-7320

September 11, 1990
Letter No.: 90-84

TO: All County Welfare Directors
All County Administrative Officers

SUBJECT: TO PROVIDE INSTRUCTIONS FOR IMPLEMENTATION OF A REVISED STANDARDIZED POTENTIAL THIRD PARTY LIABILITY FORM.

Background

Title 22 California Code of Regulations (CCR) Section 50771 (d) requires county welfare departments to provide information to the Department of Health Services when a beneficiary receives health care services as a result of an accident or injury caused by some other person's action or failure to act. Attached is a sample of the official revised form to be used by the counties for submitting third party liability information to the Casualty/Workers' Compensation Section.

Medi-Cal is currently recovering approximately $22 million annually from casualty and workers' compensation cases. It is expected that these savings can be increased and the county workload reduced by the use of this revised standard format to report these cases.

Instructions

1. Reproduce copies of the attached Notification of Potential Third Party Liability as needed and distribute to appropriate county staff with instructions on its use.

2. Upon discovery that Medi-Cal beneficiary received medical care services under the program as a result of an accident, injury, or illness caused by a third person's acts or failure to act, and either (a) the beneficiary intends to file a claim or lawsuit against the liable third party or (b) the liable third party has insurance or Workers' Compensation, complete an original and one copy of the Notification of Potential Third Party Liability. Do not complete a form unless these conditions are present.

3. Mail the original form to the Casualty/Workers' Compensation Section on a flow basis as the information is discovered.

4. File the copy in the Medi-Cal beneficiary's case file.

You may contact Stephanie Saenz, Casualty/Workers' Compensation Section, at (916) 327-2931 if you have any questions.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

To: Department of Health Services
Casualty/Worker's Compensation Section
P.O. Box 2471
Sacramento, CA 95811

Date: _____

Mail: Original
File: Copy

POTENTIAL THIRD PARTY LIABILITY NOTIFICATION

COMPLETE THIS FORM ONLY WHEN MEDI-CAL WAS USED OR WILL BE USED FOR THIS INJURY AND ONE OF THE FOLLOWING APPLY:

1. The third party has liability insurance or workers' compensation insurance.
2. The beneficiary has filed or intends to file a claim or lawsuit.

Case Name (First, Middle, Last)	Telephone Number(s):
Home Address (Number and Street)	Home
City, State & ZIP Code	Work

INJURED PERSON(S)	14-DIGIT MEDI-CAL NUMBER					DATE OF INJURY — —
NAME	COUNTY	AID	7-DIGIT SERIAL NUMBER	FBU	PERSON NUMBER	SOCIAL SECURITY NUMBER
						— —
						— —
						— —

COMPLETE THIS SECTION IF INJURIES ARE NOT WORK-RELATED.

Name of Attorney		Telephone Number
Address (Number and Street)	City, State, and ZIP Code	
Name of Person Responsible for Accident/Injury		Telephone Number
Name of Liable Insurance Company		Telephone Number
Address (Number and Street)	City, State, and ZIP Code	Policy Number

COMPLETE THIS SECTION IF INJURIES ARE WORK-RELATED.

Name of Employer at Time of Injury		Telephone Number
Address (Number and Street)	City, State, and ZIP Code	Worker's Compensation Case Number

COUNTY USE ONLY

County of	Telephone Number
Worker's Name	Worker's Number