SOCIAL SECURITY ADMINISTRATION

FORM APPROVED
OMB No. 0960-0323

THIRD PARTY LIABILITY INFORMATION STATEMENT

(See Reverse for Paperwork/Privacy Act Notice)

MEDICAID USE ONLY

CONTROL NUMBER

TYPE OF CASE

☐ INITIAL APPLICATION ☐ REDETERMINATION

FO CODE

MEDICAID ID NO.

APPLICANT'S/RECIPIENT'S NAME *(First name, middle initial, last name)*

DATE OF BIRTH *(Month, day, year)*

SOCIAL SECURITY NUMBER

APPLICANT'S/RECIPIENT'S ADDRESS *(Number and Street, Apt. No., P.O. Box or Rural Route)*

TELEPHONE NO. *(Include area code)*

CITY AND STATE

ZIP CODE

I. Do you, your spouse, parent or stepparent have any private, group, or government health insurance that pays toward the cost of your medical care? (Do not include Medicare or Medicaid.) ☐ YES ☐ NO

If "Yes," check the appropriate boxes to indicate services covered and complete sections I.a. and b.:

☐ Hospital ☐ Physician ☐ Out-Patient ☐ Emergency ☐ Laboratory Services

☐ Prescription ☐ Dental ☐ Other (Explain) _____

a.

NAME OF POLICY HOLDER

SOCIAL SECURITY NUMBER

RELATIONSHIP TO APPLICANT/RECIPIENT
☐ Self ☐ Spouse ☐ Parent ☐ Other _____

DATE OF BIRTH *(Month, day, year)*

NAME AND ADDRESS OF INSURANCE CO.

POLICY NO.

BEGINNING/ENDING DATES

GROUP NO./NAME OF EMPLOYER

b.

NAME OF POLICY HOLDER

SOCIAL SECURITY NUMBER

RELATIONSHIP TO APPLICANT/RECIPIENT
☐ Self ☐ Spouse ☐ Parent ☐ Other _____

DATE OF BIRTH *(Month, day, year)*

NAME AND ADDRESS OF INSURANCE CO.

POLICY NO.

BEGINNING/ENDING DATES

GROUP NO./NAME OF EMPLOYER

II. Do you have, or are you planning, a claim or legal action against a person or corporation because of an injury or illness? ☐ YES ☐ NO

If yes, complete the following:

What is the nature of your claim?

☐ Worker's Compensation ☐ Automobile Accident ☐ Other _____

When did the injury or illness occur? →

What is the name and address of your attorney?

What is the name and address of the person, corporation, or insurance company against which you have filed the claim?

I know that anyone who makes or causes to be made a false statement or presentation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law and/or State law. I affirm that all information I have given in this document is true.

SIGNATURE *(First name, middle initial, last name)(Write in ink)*

SIGN HERE ▶

DATE *(Month, day, year)*

PAPERWORK/PRIVACY ACT NOTICE

The information obtained on this form is collected by the Social Security Administration to help the Medicaid State agency to administer the Medicaid program. The collection of this information is authorized by law (42 U.S.C. 1396e(a)(25); 42 CFR 433.136-139). Information collected may be disclosed to Federal, State, and Local government agencies responsible for the identification of third party liability resources and collection of that liability. Other routine uses for information obtained are fully explained and published annually in the *Federal Register*. The Social Security Administration will further explain these uses upon request. Your response is required as a condition of Medicaid eligibility. This information will help the Medicaid State agency determine liability of third parties to pay for care and services. Medicaid benefits are not denied based on an applicant/recipient having health insurance

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The **Paperwork Reduction Act of 1995** requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 5 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts and fill out the form.

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