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

1. 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 1.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

2. Do you have, or are you planning, a claim or legal action against a person or corporation because of an injury or illness? If yes, complete the following: ☐ YES ☐ NO

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 declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

SIGNATURE *(First name, Middle initial, Last name)(Write in ink)*

DATE *(Month, Day, Year)*

Privacy Act Statement

See Revised Privacy And PRA Statements Attached

Collection and Use of Personal Information

Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act (42 U.S.C. § 404), as amended, authorize us to collect this information. We will use the information you provide to assist us in making a decision on your claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate decision on your claim.

We rarely use the information you supply for any purpose other than the reason stated above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notices entitled, Master Files of Social Security Number (SSN) Holders and SSN Applications System, 60-0058; Claims Folders Systems, 60-0089; and Master Beneficiary Record, 60-0090. These notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at **www.socialsecurity.gov** or at any local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 5 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***