Attachment 7

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
MEDICAID THIRD PARTY LIABILITY

Please Complete Entire Form:

MEDICAID NUMBER
_ _ _ _ _ _ _ _ _ _ _ _

PERSON NUMBERS COVERED BY INSURANCE
_ _ _ _ _ _
_ _ _ _ _ _
_ _ _ _ _ _
_ _ _ _ _ _
_ _ _ _ _ _

CASE NAME _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

FIRST NAME _ _ _ _ _ _ _ _

BIRTH DATE _ _ _ _ _ _

SOCIAL SECURITY NUMBER _ _ _ _ _ _ _ _ _

INS NUMBER	POLICY / HIC NUMBER / NUMBER	GROUP NUMBER	COV TYPE	POL HLDR	EFFECTIVE DATE	TERMINATION DATE
_ _ _	_ _ _ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _	_ _	_	_ _ _ _ _	_ _ _ _ _
_ _ _	_ _ _ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _	_ _	_	_ _ _ _ _	_ _ _ _ _
_ _ _	_ _ _ _ _ _ _ _ _ _ _ _	_ _ _ _ _ _ _ _ _ _ _ _	_ _	_	_ _ _ _ _	_ _ _ _ _

Attach Copy Of Front And Back Of Insurance Card(s)

Name of Policy Holder: _____ SSN of Policy Holder: _____-_____-_____

Name, Address and Phone Number of Insurance Carrier: _____
Name

_____ _____
Street Address City

_____
State Zip Code Telephone Number

Enter relationship of policy holder in policy holder block
Relationships are as follows:

1. Self
2. Dependent of Medicaid Head of Household
3. Absent Parent
4. Another Parent

Enter the two digit code in the coverage block which corresponds to the type of insurance coverage reflected in the policy.

The allowance codes are:
01 Inpatient Hospital
02 Medical/Surgical
03 Major Medical
04 Medicare Supplemental
05 Prescription
06 Dental
07 Optical
08 Hospital and Medical/Surgical
09 Long Term Care
11 HMO no Rx
12 Outpatient Hospital
13 Hospital Medical/Surgical and Major Medical
22 Capitated/Non-HMO Plan (PPO/EPO) plan w/o Rx
26 Mental Health

Has any case member sustained a traumatic injury in the last 5 years? __ Yes __ No If yes, name of injured party: _____
Date if injury:_____ Where did injury take place?_____ Description: _____
_____

Worker's Name (please print) _____ Worker's Telephone # _____ Date _____