



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

VELVET G. MILLER
Director

MEDICAID COMMUNICATION NO. 96-6

DATE: February 23, 1996

TO: County Welfare Agency Directors
SUBJECT: Revised Third Party Liability Forms

As a follow-up to Medicaid Communication No. 95-19, enclosed is a supply of TPL-1 (12/95) forms. These should be used in lieu of any other TPL forms now in use.

It is important that the forms be completed with all available insurance information. These forms are to be completed only if there is third party insurance, a change in third party insurance or a traumatic injury.

Forms may be obtained by submitting a request to:

Division of Medical Assistance and Health Services
General Services
CN 712

Trenton, New Jersey 08625

Fax # (609) 584-4383

Thank you for your cooperation in this matter. If you have any questions, please feel free to contact Joan Suleskey, Chief, Bureau of Technical Services, at (609) 588-2933.

Sincerely,

Velvet G. Miller
Director

VGM:MB
Attachment
c Karen Highsmith, Acting Director
Division of Family Development

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. CODE		POLICY NUMBER / HIC NUMBER								GROUP NUMBER					COV TYPE		POL HLDGR		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

Enter relationship of policy holder in policy holder block.

Relationships are as follows:

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

_____	_____	_____
<i>Street Address</i>	<i>City</i>	
_____	_____	_____
<i>State</i>	<i>Zip</i>	<i>Telephone Number</i>

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 | 07 Optical | 13 Hospital Medical/Surgical and Major Medical |
| 02 Medical/Surgical | 08 Hospital and Medical/Surgical | 14 Hospital Medical/Surgical Major Medical and Rx |
| 03 Major Medical | 09 Long Term Care | 15 Hospital Medical/ Surgical Major Medical Rx and Dental |
| 04 Medicare Supplemental | 10 HMO with Rx | 16 Hospital Medical/Surgical Major Medical Rx Dental and Optical |
| 05 Prescription | 11 HMO no Rx | 17 HMO Rx and Dental |
| 06 Dental | 12 Outpatient Hospital | 18 HMO Rx Dental and Optical |

Has any case member sustained a traumatic injury in the last 5 years ? ☐ Yes ☐ No If yes, name of injured party: _____

Date of injury: _____ Where did injury take place? _____ Description: _____