State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
CN 712
TRENTON, NEW JERSEY 08625

MEDICAID COMMUNICATION NO: 94-13 **DATE:** September 20, 1994

TO: County Welfare Agency Directors

SUBJECT: Third Party Liability

The purpose of this communication is to remind County Welfare Agencies of the need to maintain the most accurate Third Party Liability (TPL) information in case files, and to provide this information to the Medicaid Bureau of Third Party Liability for accretion to the UNISYS TPL Resource File within 60 days so that the program may process claims under the third party payment procedures contained in 42 CFR 433.138 (g)(2)(i).

When it is determined that a recipient has other health insurance coverage, including Medicare, or has added, changed, or lost insurance coverage, the agency should document this information in its case record. The information also should be forwarded to the Medicaid Bureau of Third Party Liability using Form TPL-1. A copy of Form TPL-1 and instructions for Using Form TPL-1 are attached for your reference.

Thank you for your cooperation in this matter. If you have questions regarding this procedure, please feel free to contact John F. Cooper, Chief, Bureau of Third Party Liability, at (609) 588-7104.

Sincerely,

Velvet G. Miller
Director

VGM:Cc
Attachment
c: Marion Reitz, Director
Division of Family Development

James W. Smith, Acting Director
Division of Youth and Family Services

INSTRUCTIONS FOR USING FORM TPL-1

USE: Form TPL-1 is to be filled out on all new Medicaid cases and on all cases where there is a change to third party liability (TPL) information currently on the Medicaid Eligibility File.

PURPOSE: The purpose of FORM TPL-1 is to provide information to the Bureau of Third Party Liability (BTPL) regarding recipients' alternate sources of medical coverage. The information reported on Form TPL-1 will be further developed by the DMAHS BTPL staff for accretion to the Medicaid Eligibility System screen 062; details of verified coverage will then be returned to the providing agency for its paper case file and accretion to FAMIS in AFDC-related cases.

GENERAL INSTRUCTIONS: Answer items 1-5 "YES" when there is a positive response to the question. If the answer to a question is "unknown," check "NO"; however, if the answer to a question is "yes" but details are unknown, check "YES" and enter as much information as possible (e.g., a city name if no street address is available). When the case name is that of a child, "ABSENT PARENT" information, including Social Security Number and employment, should be given for any parent not in the case. Added responses may be shown on the back of Form TPL-1.

SPECIFIC INSTRUCTIONS:

INTAKE/CHANGE: Check whichever is appropriate.

COUNTY CODE: Indicate your county, the agency submitting Form TPL-1.

1. CASE NAME: Enter the case name, last name first.
   MEDICAID NO.: Enter the 10-digit Medicaid number.
2. IS THERE AN ABSENT PARENT IN THIS CASE?: Check whichever is appropriate and provide as much information as possible. Identify the children for which each absent parent is responsible.
3. IS A CASE MEMBER OR ABSENT PARENT EMPLOYED OR RECEIVING A PENSION?: Check whichever is appropriate.
4. DOES A CASE MEMBER OR ABSENT PARENT HAVE HEALTH INSURANCE OR MEDICARE?: Check whichever is appropriate and attach a copy of the ID card if available.
5. HAS ANY CASE MEMBER BEEN INVOLVED IN AN INCIDENT/ACCIDENT WITHIN THE PAST 5 YEARS FOR WHICH MEDICAL TREATMENT WAS OBTAINED?: Check whichever is appropriate.

WORKER'S NAME/DATE: Print the name of the person completing this Form TPL-1 and the date of completion.

FORM SUBMISSION: Completed Forms TPL-1 should be submitted weekly to:

DMAHS BTPL
CN 720
TRENTON NJ 08625-0720

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

THIRD PARTY LIABILITY INFORMATION

PLEASE PRINT
USE OTHER SIDE IF NECESSARY

INTAKE ___ **CHANGE** ___ **COUNTY CODE** _ _

1. CASE NAME _____ **MEDICAID NO.** _ _ _ _ - _ _ _ _ _ _

2. IS THERE AN ABSENT PARENT IN THIS CASE? YES ___ NO ___

NAME _____ (LAST) (FIRST)

ADDRESS _____

_____

SSN _____

DATE OF BIRTH _____

CHILDREN _____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

3. IS A CASE MEMBER OR ABSENT PARENT EMPLOYED OR RECEIVING A PENSION? YES ___ NO ___

NAME OF CASE MEMBER OR ABSENT PARENT _____

NAME AND LOCATION OF PRESENT OR FORMER EMPLOYER OR UNION _____

_____

4. DOES A CASE MEMBER OR ABSENT PARENT HAVE HEALTH INSURANCE OR MEDICARE? YES ___ NO ___
ATTACH COPY OF FRONT AND BACK OF INSURANCE CARD(S) **OR** COMPLETE THE FOLLOWING:

NAME OF INSURED _____

GROUP/POLICY NUMBER _____

ID NUMBER _____

MEDICARE NUMBER _____

NAME AND ADDRESS OF INSURANCE CARRIER

_____

_____

_____

5. HAS ANY CASE MEMBER BEEN INVOLVED IN AN INCIDENT/ACCIDENT WITHIN THE PAST 5 YEARS FOR WHICH MEDICAL TREATMENT WAS OBTAINED? YES ___ NO ___

NAME OF INJURED PARTY _____ DATE OF INCIDENT/ACCIDENT _____

WHERE DID THE ACCIDENT TAKE PLACE?

__ AUTOMOBILE
__ HOME
__ PRODUCT LIABILITY
__ PLACE OF WORK
__ SCHOOL
__ MEDICAL MALPRACTICE
__ COMMERCIAL ESTABLISHMENT
__ PRIVATE PROPERTY
__ OTHER (IDENTIFY)

WORKER'S NAME _____ DATE _____
(PLEASE PRINT)

TPL-1 (1/89)

ABSENT PARENT (CON'T)

NAME _____ (LAST) (FIRST)

ADDRESS _____

_____

SSN _____

DATE OF BIRTH _____

CHILDREN _____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

NAME _____ (LAST) (FIRST)

ADDRESS _____

_____

SSN _____

DATE OF BIRTH _____

CHILDREN _____ (LAST) (FIRST

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

_____ (LAST) (FIRST)

EMPLOYMENT OR PENSION (CON'T)

NAME OF CASE MEMBER OR ABSENT PARENT _____

NAME AND LOCATION OF PRESENT OR FORMER EMPLOYER OR UNION _____

_____

NAME OF CASE MEMBER OR ABSENT PARENT _____

NAME AND LOCATION OF PRESENT OR FORMER EMPLOYER OR UNION _____

_____

HEALTH INSURANCE (CON'T)

NAME OF INSURED _____

GROUP/POLICY NUMBER _____

ID NUMBER _____

MEDICARE NUMBER _____

NAME AND ADDRESS OF INSURANCE CARRIER

_____

_____

_____

NAME OF INSURED _____

GROUP/POLICY NUMBER _____

ID NUMBER _____

MEDICARE NUMBER _____

NAME AND ADDRESS OF INSURANCE CARRIER

_____

_____

_____