10/21/09

State of South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 100127
Columbia, South Carolina 29202-3127

XXXXXXXXXXXXXXXXX		MEDICAID #:
XXXXXXXXXXXXXXXXX		PROVIDER:
XXXXXXXXX	XX XXXXX	DATE OF SERVICE:

Medicaid has made payments for medical services provided to you. The following information is necessary to determine if other sources of payment are available for recovery of Medicaid funds. It is the applicant or eligible beneficiary's responsibility to take reasonable measures to identify and report resources and assist the Department in obtaining information and payment from these resources.

Please answer all applicable questions on the reverse side. Upon completion, please sign and date below.

This letter should be returned within two weeks in the enclosed self-addressed envelope.

MEDICAID ASSIGNMENT OF BENEFITS

In accordance with the eligibility requirements for the South Carolina Medicaid Program, I hereby assign to the SC Department of Health and Human Services all rights to benefits otherwise payable to me for hospital, surgical or medical services rendered to myself or any of my dependents, and I authorize payment of said benefits directly to the South Carolina Department of Health and Human Services, the state Medicaid agency. I fully understand this assignment and acknowledge that I have an obligation to reimburse the state of South Carolina for hospital and medical expenses paid on my behalf or on the behalf of my dependents, in the event I have a right of recovery under any policy of insurance, or against any person who may be liable for the medical expenses.

Signature: _____ **Date**: _____

Over

MEDICAID ACCIDENT QUESTIONNAIRE

What is your telephone number? _____ Date of Accident: _____

Where did it occur? ( ) Auto ( ) Work ( ) School ( )/Home ( ) No Accident ( ) Other_____

Describe your injury: _____

_____

Did you hire an attorney? ( ) Yes ( ) No Attorney Name: _____

Attorney Telephone No.: _____

Do you have **medical insurance**, in addition to Medicaid? ( ) Yes ( ) No Policy Number is: _____

Insurance Company is: _____

If you were hurt in a **car accident,** please answer the following questions**,** were you the ( ) driver ( ) passenger ( ) pedestrian

YOUR VEHICLE INFORMATION:

Name of Driver: _____

Name of Owner:_____

Insurance Company: _____

Claims Adjuster Name: _____ _

Telephone: _____

Policy or Claim Number: _____

OTHER VEHICLE INFORMATION:

Name of Driver: _____

Name of Owner: _____

Insurance Company: _____

Claims Adjuster Name: _____

Telephone: _____

Policy or Claim Number: _____

PLEASE ATTACH COPY OF ACCIDENT REPORT IF AVAILABLE

If someone has been **arrested** because of hurting you, please answer these questions:

Name of person who hurt you: _____ What jail is that person in? (City, county) _____

If you were hurt at **school,** please answer these questions:

School Name: _____

School Insurance Company Name: _____ Do you have school insurance: ( ) Yes ( ) No

School Insurance policy number is: _____ Did the accident take place during a **sports event**? ( ) Yes ( ) No

PLEASE ATTACH COPY OF COMPLETED SCHOOL CLAIM FORM

If you were hurt at **someone's house**, not the house you live in, please answer these questions:

Address of house: _____ Who lives there? (name) _____

Phone number for this house: _____ Who's fault was the accident: _____

Homeowner's Insurance Company Name & Policy Number: _____

Thank You!