Request for Medicaid Payment Itemization

Today's Date: _____

Client's Name: _____ _____ _____ Medicaid ID : _____
(Last) (First) (MI)

Parent's Name(s) if minor: _____ SSN: _____

Date of Accident: _____ Type _____ Date of Birth: _____

Is Client Deceased? __ Yes __ No If Yes, Date of Death: _____

Estate Probated? __ Yes __ No If Yes, Date Probated: _____ Client County _____

Plaintiff's Attorney of Record: _____ _____ _____ _____

Name of Law Firm: _____ Email: _____

Mailing Address: _____ _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax #: _____ Contact Person: _____

How was the client injured? _____

Briefly describe the client's injuries: _____

Still Treating? __ Yes __ No Last Date Treated: _____

Insurance Information:

(1) Liability Carrier:

Ins. Co. Name: _____

Address: _____

_____ _____ _____

Insured: _____

Claim #: _____

Adjuster: _____

Phone #: _____ Ext: _____

Policy Limits: _____

(2) Other

Specify __ UIM __ UM __ Other

Ins. Co. Name: _____

Address: _____

_____ _____ _____

Insured: _____

Claim #: _____

Adjuster: _____

Phone #: _____ Ext: _____

Policy Limits: _____

Has suit been filed? __ Yes __ No

Please provide the name and address of the defense attorney(s):

( ) Mr. ( ) Ms. _____ _____ Firm: _____
Last First

Address: _____ _____ _____ _____

Has this case settled? __ Yes __ No How much? _____

More to come? __ Yes __ No Disbursed? __ Yes __ No Date: _____