

**HUMAN RESOURCES ADMINISTRATION
INVESTIGATION, REVENUE AND
ENFORCEMENT ADMINISTRATION**
DIVISION OF LIENS AND RECOVERY
P.O. Box 3786 – Church Street Station
New York, NY 10008-3786
Phone: (212) 274-5892



ROBERT DOAR
Administrator / Commissioner

MEDICAID INFORMATION Fax Form
Fax #: (212) 274-4988 or (212) 274-5603

For Insurance Company Use Only

MEDICAID INSURED PARTY INFORMATION

MEDICAID INSURED PARTY NAME: _____
(Individual making a claim against your insured)
MEDICAID INSURED PARTY SSN: _____ DOB: _____ CASE/CIN#: _____

INSURANCE COMPANY INFORMATION

NAME OF YOUR INSURED: _____
INSURANCE COMPANY NAME: _____
INSURANCE COMPANY ADDRESS: _____
PHONE: _____ FAX: _____ EMAIL: _____
NATURE OF INJURY: _____ DATE OF INCIDENT: _____
SETTLEMENT AMOUNT: _____ DATE FUNDS DISTRIBUTED: _____ POLICY LIMIT: _____
CAPTION # (If Applicable): _____ INDEX #: _____
NO FAULT? YES NO
INSURANCE CO. CONTACT PERSON/ADJUSTER: _____

INSURED ATTORNEY INFORMATION

ATTORNEY NAME REPRESENTING YOUR INSURED: _____
FIRM NAME: _____
FIRM ADDRESS: _____
PHONE: _____ FAX: _____

PLAINTIFF ATTORNEY INFORMATION

ATTORNEY NAME REPRESENTING MEDICAID INSURED PARTY: _____
FIRM NAME: _____ FIRM ADDRESS: _____
PHONE: _____ FAX: _____ EMAIL: _____

Prepared by: _____ Phone: _____ Date: _____
(PLEASE PRINT)