MEDICAID SUBROGATION REQUEST FORM

REFERRING ATTORNEY/INSURANCE CO.:_____

ADDRESS: _____

TELEPHONE NO: _____ FAX NO: _____

****

1. CLIENT NAME: _____

2. DATE OF BIRTH: _____ DATE OF ACCIDENT: _____

3. SS#:_____ MID#: _____

4. POLICE REPORT ATTACHED YES_____ NO_____

5. PETITION ATTACHED: YES_____ NO_____

6. INJURIES 1._____ 3._____

   2._____ 4._____

7. TREATING HEALTH CARE PROVIDERS

   1._____ 3_____

   2._____ 4_____

8. INSURANCE COMPANY: _____

   CLAIM/POLICY NO.: _____

   ADJUSTER/PHONE#:_____

   ATTORNEY/PHONE#:_____

9. MEDIATION DATE: _____ARBITRATION DATE: _____

   SETTLEMENT DATE: _____TRIAL DATE: _____

10. NOTES/COMMENTS: _____

_____

_____

_____