



**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)

CHILDREN \_\_\_\_\_  
(LAST) (FIRST)

ADDRESS \_\_\_\_\_

(LAST) (FIRST)

SSN \_\_\_\_\_

(LAST) (FIRST)

DATE OF BIRTH \_\_\_\_\_

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 \_\_\_\_\_

NAME AND ADDRESS OF INSURANCE CARRIER

GROUP/POLICY NUMBER \_\_\_\_\_

ID NUMBER \_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_

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

\_\_\_ PLACE OF WORK

\_\_\_ COMMERCIAL ESTABLISHMENT

\_\_\_ HOME

\_\_\_ SCHOOL

\_\_\_ PRIVATE PROPERTY

\_\_\_ PRODUCT LIABILITY

\_\_\_ MEDICAL MALPRACTICE

\_\_\_ OTHER (IDENTIFY)

WORKER'S NAME \_\_\_\_\_

DATE \_\_\_\_\_

(PLEASE PRINT)

**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 AND ADDRESS OF INSURANCE CARRIER \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_

GROUP/POLICY NUMBER \_\_\_\_\_

ID NUMBER \_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_

NEW JERSEY  
STATE DEPT. OF HUMAN SERVICES  
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SEP 21 1994  
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