State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

VELVET G. MILLER
Director

MEDICAID COMMUNICATION NO. 96-6 **DATE:** February 23, 1996

TO: County Welfare Agency Directors

SUBJECT: Revised Third Party Liability Forms

As a follow-up to Medicaid Communication No. 95-19, enclosed is a supply of TPL-1 (12/95) forms. These should be used in lieu of any other TPL forms now in use.

It is important that the forms be completed with all available insurance information. These forms are to be completed only if there is third party insurance, a change in third party insurance or a traumatic injury.

Forms may be obtained by submitting a request to:

Division of Medical Assistance and Health Services
General Services
CN 712
Trenton, New Jersey 08625

Fax # (609) 584-4383

Thank you for your cooperation in this matter. If you have any questions, please feel free to contact Joan Suleskey, Chief, Bureau of Technical Services, at (609) 588-2933.

Sincerely,

Velvet G. Miller
Director

VGM:MB
Attachment
c Karen Highsmith, Acting Director
Division of Family Development

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

MEDICAID THIRD PARTY LIABILITY

Please Complete Entire Form:

MEDICAID NUMBER

PERSON NUMBERS COVERED BY INSURANCE

CASE NAME | FIRST NAME | BIRTH DATE | SOCIAL SECURITY NUMBER

INS. CODE	POLICY NUMBER / HIC NUMBER	GROUP NUMBER	COV TYPE	POL HLDR	EFFECTIVE DATE	TERMINATION DATE

Attach Copy Of Front And Back Of Insurance Card(s)

Name of Policy Holder: _____ SSN of Policy Holder: _____ – _____ – _____

Name, Address and Phone Number of Insurance Carrier: _____
Name

_____ _____
Street Address *City*

_____ _____ – _____ – _____
State *Zip* *Telephone Number*

Enter relationship of policy holder in policy holder block.
Relationships are as follows:

1. Self
2. Dependent of Medicaid Head of Household
3. Absent Parent
4. Another Adult

Enter the two digit code in the coverage block which corresponds to the type of insurance coverage reflected in the policy.
The allowance codes are:

01 Inpatient Hospital
02 Medical/Surgical
03 Major Medical
04 Medicare Supplemental
05 Prescription
06 Dental
07 Optical
08 Hospital and Medical/Surgical
09 Long Term Care
10 HMO with Rx
11 HMO no Rx
12 Outpatient Hospital
13 Hospital Medical/Surgical and Major Medical
14 Hospital Medical/Surgical Major Medical and Rx
15 Hospital Medical/ Surgical Major Medical Rx and Dental
16 Hospital Medical/Surgical Major Medical Rx Dental and Optical
17 HMO Rx and Dental
18 HMO Rx Dental and Optical

Has any case member sustained a traumatic injury in the last 5 years ? ☐ Yes ☐ No If yes, name of injured party: _____

Date of injury: _____ Where did injury take place? _____ Description: _____

_____

_____