

STATEMENT OF CLAIM REQUEST FORM

DECEDENT'S NAME:	
DECEDENT'S LAST KNOWN ADDRESS: <i>(Prior to entering nursing home)</i>	
	<i>(CITY, STATE, ZIP CODE)</i>
DECEDENT'S SOCIAL SECURITY NUMBER:	/ /
DECEDENT'S DATE OF BIRTH:	
DECEDENT'S DATE OF DEATH:	
GROSS AMOUNT OF DECEDENT'S ESTATE: <i>(Written documentation must be included)</i>	
PERSONAL REPRESENTATIVE'S NAME:	
PERSONAL REPRESENTATIVE'S ADDRESS:	
	<i>(CITY, STATE, ZIP CODE)</i>
PERSONAL REPRESENTATIVE'S PHONE NUMBER:	()
ATTORNEY'S NAME:	
ATTORNEY'S ADDRESS:	
	<i>(CITY, STATE, ZIP CODE)</i>
ATTORNEY'S PHONE NUMBER:	()

SEND TO:

**DEPARTMENT OF PUBLIC WELFARE
DIVISION OF THIRD PARTY LIABILITY**

ESTATE RECOVERY PROGRAM

P.O. Box 8486
Harrisburg, PA 17105-8486

Estate Recovery Hotline
1-800-528-3708

Facsimile #: (717) 772-6553