



pennsylvania
DEPARTMENT OF HUMAN SERVICES

MEDICAL SERVICES QUESTIONNAIRE

CIS #:	
Case #:	

Marque aqui si usted necesita esta forma en español. Devuelva la forma en el sobre timbrado adjunto.

**FAILURE TO FILL OUT AND RETURN THIS FORM WITHIN 15 DAYS
MAY AFFECT YOUR BENEFITS**

Diagnosis:
Procedure:

Medical Assistance paid bills for _____ to _____ for service on _____

We need to know if another insurance company or person should have paid these bills. To find out, we need you to fill out this form and return it in the enclosed envelope.

Please check the reason for the visit:

- Motor Vehicle (includes car, bus, truck, van, motorcycle, ATV or other type of vehicle)
- Slip and/or Fall
- Medical Malpractice
- Burn
- Animal Bite
- Attack by Another Person - Name of attacker: _____
- District Attorney information: _____ Docket number: _____
- Work Injury - Name of employer: _____
- Other (include onetime or ongoing illness): _____

Date of accident, injury or illness: _____

Body parts injured: _____

If an attorney is involved, please provide any of the following information if you know it:

Attorney Name: _____

Attorney Address: _____

Attorney Telephone Number: _____ Fax Number: _____

If an insurance company is involved (including Workers Comp Carrier), please provide any of the following information if you know it:

Insurance Company Name: _____

Policy Holder Name: _____

Policy Number: _____

Claim Number: _____

Adjuster/Claim Representative Name: _____

Claim Office Address: _____

Claim Office Telephone Number: _____ Fax Number: _____

Please explain how accident, injury or illness happened:

Name of person who filled out this form: _____

Date this form was filled out: _____

Daytime phone number of person who filled out this form: _____

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM, PLEASE CALL THE DIVISION OF THIRD PARTY LIABILITY AT 1-866-850-8117; OTHERWISE CALL YOUR LOCAL COUNTY ASSISTANCE OFFICE.