# GEORGIA DEPARTMENT OF COMMUNITY HEALTH – THIRD PARTY LIABILITY
# HEALTH INSURANCE INFORMATION QUESTIONNAIRE

CASE NAME:_____ CASE NO:_____

ADDRESS: _____ SSN: _____

_____ PHONE NO:_____

TYPE OF CASE: ☐ INITIAL APPLICATION ☐ SPECIAL NEEDS TRUST (SNT) ☐ CHANGE ☐ CANCELLATION
(Check all that apply) ☐ HIPP REFERRAL EFFECTIVE DATE OF CHANGE OR CANCELLATION:_____/____/_____

The information obtained on this form is collected by the Georgia Department of Community Health, Third Party Liability Section. The collection of this information is authorized by law (42 U.S.C. 1396(a) (25): 42 CFR 433.135-139). It will be used to determine the liability of third parties to pay for care and services and collection of that liability. Medicaid benefits are not denied based on any applicant having health insurance or medical coverage.

Do you have a private, group or government health insurance that pays any of the cost of your medical care? (Do not include Medicare or Medicaid) ☐ YES ☐ NO

Does your spouse, parent or stepparent have any private, group or government health insurance that pays any of the cost of your medical care? ☐ YES ☐ NO

Is policyholder an Absent Parent? ☐ YES ☐ NO

| Names of Covered Individuals in Household (Last) (First) (MI) | Medicaid ID# | SSN | Relationship to Policy Holder (check one) | | | | | Date Of Birth |
|---|---|---|---|---|---|---|---|---|
| | | | Policy Holder | Spouse | Child | Step-child | Other | |
| | | | | | | | | |
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| | | | | | | | | |

Are any of these persons pregnant? ☐ YES ☐ NO If yes, Name _____ Date of Delivery_____

**ATTACH A COPY OF INSURANCE CARD/POLICY AND A COPY OF SNT**

Do any of the persons listed above have a chronic medical condition? ☐ YES ☐ NO If yes, Name_____ Condition_____

_____(_____)_____
(Insurance Company Name) (Telephone Number)

_____
(Address) (City) (State) (Zip)

_____
(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

_____
(Policy Effective Date) (Policy Termination Date)

_____
(Employer Name) (Telephone Number)

_____
(Employer Address) (City) (State) (Zip)

Types of Coverage (circle those which apply)

| | |
|---|---|
| 01 – HOSPITAL INPT. | 15 – LTC/NH |
| 07 – DRUG/STND | 16 – HMO/DRUG |
| 08 – MAJOR MED. | 17 – MED. SUPP A |
| 09 – DENTAL | 18 – MED. SUPP B |
| 10 – VISION | 22 – HMO/STND |

OTHER_____

I authorize the release of information necessary to identify health/liability insurance benefits to the Department of Community Health. I also certify that the above information is correct.

Signed_____ Date_____
Member or Authorized Person

I hereby assign to the Department of Community Health all rights to payments for benefits of medical services rendered to myself or any of my dependents who receive Medicaid.

Signed_____Date_____
Insured or Authorized Person

EFFECTVIE DATE OF MEDICAID ELIGIBILITY_____

Case Worker Name:_____ Phone No:_____County_____

DMA-285-REV. (01/06)