

ACCIDENT REPORTING FORM

PURPOSE:

This form is to be completed when a child in the custody of the Division of Family Services (DFS) and receiving Medicaid sustains injuries in an accident or work related incident. In many instances a third party may be partially or totally responsible for payment of medical costs incurred due to the injuries. The Department of Social Services (DOSS) has a right to recover from any person, corporation, institution, public agency or private agency that part of an award or settlement which is reimbursement for medical expenses. This form will be used to notify the Division of Medical Services (DMS) when an injury has been incurred and who may be responsible.

NUMBER OF COPIES AND DISTRIBUTION:

The form consists of two self-carboning pages. The white (original) copy is to be submitted to Division of Medical Services while the canary copy is to be filed in the child's record. If the injury is sustained in a Service County the Service County shall complete the form and provide the case manager with a copy.

INSTRUCTIONS FOR COMPLETION:

The TPL-2 may be generated by the Third Party Liability (TPL) Unit to the county office if they become aware of an accident. In this event, the TPL Unit will complete the top section through field 4. The county staff shall complete fields 5 through 22.

If the TPL-2 is being initiated by the county staff, the county staff shall complete the entire form.

Do not hesitate to go into great detail in completion of this form. Frequently inconsequential information is the key which enables DMS to be successful in the investigation of third party liability leading to benefit recovery.

Field 1. Name of Claimant: Enter the last, first, and middle name or initial of the recipient who was injured in the accident.

Field 2. Medicaid Identification Number: Enter the eight digit departmental client number (DCN) for the recipient who was injured in the accident.

Field 3. Date of Service: Enter the date of service on which the recipient received medical care relating to the accident/injury.

- Field 4. Provider: Enter the name of the hospital, physician, ambulance, etc., who provided the medical care relating to the accident/injury.
- Field 5. Date of Accident/Injury: Enter the date on which the accident/injury occurred. A precise date of accident is essential when we request copies of accident reports from law enforcement agencies.  
Type of Accident: Check the appropriate box indicating whether the accident was "Auto", "Work-Related", or "Other".
- Field 6. Location of Accident/Injury: Enter the street address, city, state, zip code, of the location of the accident/injury (where the accident/injury occurred).
- Field 7. Name and Address of Claimant's Attorney, if Any: Enter the complete name and address of the attorney, if the recipient or the recipient's guardian or family has obtained the services or hired an attorney to represent the recipient in a claim against a liable party.

Complete Section I, II, or III, whichever appropriate based on type of accident.

SECTION I - WORK RELATED ILLNESS OR INJURY

If the accident/injury occurred at the place of employment or was a work related illness, complete this section.

- Field 8. Employer's Name at Time of Illness/Injury: Enter the name of the employer and/or place of employment at time the illness/injury occurred.
- Field 9. Employer's Address: Enter the Street, City, State, and Zip Code of address of the employer listed in Field 8.
- Field 10. Dept.: Enter the department the recipient was employed in at time of the accident/injury, if applicable.
- Field 11. Accident Claim Number: Enter the employer's Workmen's Compensation insurance carrier claim or policy number.
- Field 12. Employer's Insurance Company, Name, and Address: Enter the complete name and address of the employer's Workmen's Compensation insurance carrier.

SECTION II - AUTOMOBILE ACCIDENT

If the accident/injury was an automobile, bus, truck, or travel accident, complete this section.

- Field 13. Name of the Police Department Accident Report Filed:  
Enter the name of the police office, sheriff office, or

Highway Patrol office who investigated or filed the accident report. (If available, attach a copy of the accident report.)

- Field 14. The Claimant was (a) driver, (b) passenger, (c) struck by the vehicle: Circle the appropriate item; a, b, or c.
- Field 15. Name and Address of Owner of Vehicle: Enter the name and address of the owner of the vehicle which the claimant was either driving, or was a passenger in, or was struck by, as indicated in Field 14.
- Field 16. Name and Address of Driver of Vehicle if (b) or (c) Circled: Enter the name and address of the driver of the vehicle if in Field 14 you circled item (b) or (c).
- Field 17. Name of Insurance Company of Owner or Driver of Vehicle: Enter name (and address if available) of the insurance company of the owner or driver of the vehicle.
- Field 18. Policy Number: Enter the policy number of the insurance company of the owner or driver of the vehicle.
- Field 19. Accident Claim Number: Enter the claim number of the insurance company of the owner or driver of the vehicle.

Some auto or truck accidents involve more than one vehicle. Items 15-18 should be completed for all vehicles involved. Since there is no available space on the form for more than one vehicle, you should use the reverse side or attach to the completed TPL-2 an IOC giving the information on the additional vehicles with explanation.

### SECTION III - OTHER ACCIDENTS

Complete this section, if the injury is a result of an accident other than a work related or auto accident. For example, an accident which occurs on someone else's property or in their home, where homeowners' insurance would be possibly liable; product liability insurance might cover injuries sustained as a result of a default in a particular product; chemical poisoning; food poisoning in a restaurant; assault; improperly maintained rental property, i.e., faulty wiring, defective heating and cooling units.

- Field 20. Person who Caused Accident or Owner of Premises: Enter complete name (and address if available), of person who caused the accident, or owner of property, or company name (in product liability cases).

Field 21. Insurance Company Covering Premises or Person: Enter complete name (and address if available), of insurance company carrier for Field 20.

Field 22. Policy or Claim Number: Enter policy number or claim number of insurance company entered in Field 21.  
Briefly Describe What Happened: Enter explanation of the circumstances surrounding this accident.

The Children's Services worker should sign on the blank line at bottom right hand corner of the TPL-2 and enter date the form was signed. Please submit the completed TPL-2 form as soon as possible to TPL Unit, Division of Medical Services, State Office.

FORMS RETENTION:

Retain this form until the entire case record is destroyed.