Ohio Department of Medicaid

INSTRUCTIONS FOR COMPLETING ODM 06613, ACCIDENT/INJURY INFORMATION

Recipient Data

1. Insert the county, case name, and case number.

Section I

1. List names of individuals involved in an accident or injury which required medical treatment.
2. List individuals' "Recipient I.D. number, Date of Birth and Social Security Number.
3. Complete as much information regarding the accident/injury as available.

   Information provided on this form will be used in the recovery of Medicaid expenses from the individual(s) at fault.

   The most essential information elements are:
   a. Date of accident/injury.
   b. Date of birth.
   c. Social Security Number.
   d. Recipient I.D. Number.
   e. Name and address of party at fault.
   f. Name and address of insurance company of the party at fault.
   g. Name and address of attorney representing the injured recipient, if an attorney has been secured.
   h. Give a detailed explanation of the accident/injury. If "other" was checked, describe circumstances, for example: dog bite, malpractice, injury by a consumer product.

Section II

1. Obtain the recipient or legal guardian's signature and date of signature. The submitter of this form should ensure the recipient or legal guardian understands that the information will be used to recover medical expenses as authorized by the Ohio Revised Code.
2. If the recipient or legal guardian has a telephone, enter the phone number.
3. The caseworker who assists in completion of this form must sign as a witness and date.

Submit to:

The Ohio Department of Medicaid
TPL Section
Fax: (614) 728–0757
E-mail: TPLFAX@medicaid.ohio.gov

The submitter of this form should retain a copy, provide one copy to the recipient or legal guardian and forward a copy to the IV-A or IV-D Section as applicable.