Arkansas Department of Human Services
Division of County Operations
THIRD PARTY RESOURCE / MEDICAL INSURANCE

A. APPLICANT INFORMATION:

1. Last Name	2. First Name	3. MI	4. Sex	5. Social Security Number

6. Applicant's Address	7. City	8. ST	9. Zip

10. Other than Medicare, do you have health insurance or some other insurance, settlement, person or group that is responsible for paying all or part of your medical expenses?

❑**Yes** If Yes, please either attach proof of coverage (such as a copy of your insurance card) **OR** complete B, C and D below.

❑**No** If No, please skip to Section F and provide a phone number, sign and date the form, and mail it to us.

B. POLICYHOLDER INFORMATION:

11. Policyholder's Last Name	12. First Name	13. MI	14. Social Security Number

15. Policyholder's Address	16. City	17. ST	18. Zip

C. INSURANCE INFORMATION:

19. Name of Insurance Company	20. Policy Number	21. Policy Effective Dates	
		From / /	To / /

22. Address of Claims Office	23. City	24. ST	25. Zip

26. Check all Type of Benefits/Coverage Applicable (at least one must be checked)

☐ 1. Medical	☐ 4. Vision	☐ 7. Indemnity/Hospital/Cancer/Heart
☐ 2. Pharmacy	☐ 5. Medicare Supplement	☐ 8. Accident Only (non-Auto)
☐ 3. Dental	☐ 6. Long Term Care	☐ 9. Automobile/Motorcycle Accident
		☐ 10. Other _____

D. INDICATE ALL INDIVIDUALS COVERED BY POLICY:

27. Last Name	28. First	29. MI	30. Relationship	31. SSN or Medicaid Number

E. COMMENTS _____

_____

F. TELEPHONE NUMBER WHERE YOU CAN BE REACHED BETWEEN 8:00/4:30 _____

AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release information needed for this or a related Medicaid claim to the Arkansas Medicaid program. I authorize the further release of any such information to any other parties who may be liable for any of my medical expenses. I hereby authorize and request that funds, settlement or other payments made by or on behalf of third parties, including tort-feasors or insurers, arising out of this Medicaid claim be paid directly to the Arkansas Medicaid program. I also assign all rights in any settlement made by me or on my behalf and arising out of any claim of which this is a part to the extent of medical expenses paid by Medicaid whether or not a portion of such settlement is designated as being for medical expenses. Any such funds received by me shall be paid to the Arkansas Medicaid program. I permit a copy of this authorization to be used in place of the original.

_____ _____

Applicant/Recipient signature (or parent/guardian if minor) Date

DHS County Office Only below:

Fold in half or tape ends together and Mail to Third Party Liability Unit

---

Division of Medical Services
Third Party Liability Unit
P.O. Box 1437, Slot S296
Little Rock, AR 72203-1437