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

CASE NAME: Susie S. Smith CASE NO:

ADDRESS: 123 Jump Street SSN: xxx-xx-xxxx

Atlanta, GA 30338 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 None currently covered by Medicaid (Last) (First) (MI)	Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
			Policy Holder	Spouse	Child	Step-child	Other	

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 Susie Smith Condition ABC123 Genetic Disorder

Blue Cross Blue Shield (800) 123-4567
(Insurance Company Name) (Telephone Number)

1001 Main Street Atlanta GA 30338
(Address) (City) (State) (Zip)

Sam S. Smith xxx-xx-xxxx ABC######### XX/XX/XXXX
(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

1/1/2020 12/31/2020
(Policy Effective Date) (Policy Termination Date)

Johnson & Johnson 706.123.4567
(Employer Name) (Telephone Number)

4321 Back Bay Ave Atlanta GA 30338
(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.

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_____
Member or Authorized Person

Signed_____Date_____
Insured or Authorized Person

EFFECTIVE DATE OF MEDICAID ELIGIBILITY_____

Case Worker Name:_____ Phone No:_____County_____

DMA-285-REV. (01/06)