State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

VELVET G. MILLER
Director

MEDICAID COMMUNICATION NO. 95-19 **DATE:** November 28, 1995

TO: County Welfare Agency Directors
Institutional Services Section (ISS) Area Supervisors
Medicaid District Office Managers

SUBJECT: Revised Third Party Liability Forms

As you may be aware, in accordance with State law, Medicaid recipients are required to utilize third party liability resources before Medicaid. The TPL-1 is used to capture and relay information of Third Party Liability or information which could lead to the recovery of resources for Medicaid. When it is determined that a recipient has other health insurance coverage, including Medicare, or has changed, added, or lost insurance coverage, the TPL-1 form should be filled out and forwarded to the Bureau of Technical Services after documenting the information for your records. The TPL-1 form should also be completed if there has been a traumatic injury where recoveries may be made by Medicaid.

The TPL-1 form has been revised to facilitate the identification and system input of completed insurance information for Medicaid recipients. The revised forms are self-explanatory and are to be completed **only** if there is third party insurance, a change in third party insurance or a traumatic injury. A sample is attached for your information. Until the print order is received and distributed, you may reproduce the form locally.

It is important that the Third Party Liability forms be completed with all available insurance information. When completed, the TPL-1 forms should be submitted weekly to:

Division of Medical Assistance and Health Services
Bureau of Technical Services
Third Party Liability Intake Unit
Mail Code #48
CN 712
Trenton, New Jersey 08625

Forms may be obtained from Medicaid by requesting new forms from:

Division of Medical Assistance and Health Services
General Services
CN 712
Trenton, New Jersey 08625

Fax # (609) 584-4383

Thank you for your cooperation in this matter. If you have any questions regarding this matter, please feel free to contact Joan Suleskey, Administrator, Bureau of Technical Services, at (609) 588-2933.

Sincerely,

Velvet G. Miller
Director

VGM:MB
Attachment

c Karen Highsmith, Acting Director
Division of Family Development

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

MEDICAID THIRD PARTY LIABILITY

Please Complete Entire Form:

MEDICAID NUMBER

PERSON NUMBERS COVERED BY INSURANCE

CASE NAME | FIRST NAME | BIRTH DATE | SOCIAL SECURITY NUMBER

INS. CODE	POLICY NUMBER / HIC NUMBER	GROUP NUMBER	COV TYPE	POL HLDR	EFFECTIVE DATE	TERMINATION DATE

Attach Copy Of Front And Back Of Insurance Card(s)

Name of Policy Holder: _____ SSN of Policy Holder: ____ – ____ – ____

Name, Address and Phone Number of Insurance Carrier: _____

_____

_____

Enter relationship of policy holder in policy holder block.
Relationships are as follows:

1. Self
2. Dependent of Medicaid Head of Household
3. Absent Parent
4. Another Adult

Enter the two digit code in the coverage block which corresponds to the type of insurance coverage reflected in the policy.
The allowance codes are:

01 Inpatient Hospital
02 Medical/Surgical
03 Major Medical
04 Medical Supplemental
05 Prescription
06 Dental
07 Optical
08 Hospital and Medical/Surgical
09 Long Term Care
10 HMO with Rx
11 HMO no Rx
12 Outpatient Hospital
13 Hospital Medical/Surgical and Major Medical
14 Hospital Medical/Surgical and Major Medical and Rx
15 Hospital Medical/ Surgical Major Medical Rx and Dental
16 Hospital Medical/Surgical Major Medical Rx Dental and Optical
17 HMO Rx and Dental
18 HMO Rx Dental and Optical

Has any case member sustained a traumatic injury in the last 5 years ? ☐ Yes ☐ No If yes, name of injured party: _____

Date of Injury: _____ Where did injury take place? _____ Description: _____

_____

_____ _____
Worker's Name (please print) *Date*