Fax Transmittal Form

Fax: 855-467-3970
Attn: Case Notification Clerk
Department of Community Health
Medicaid- Subrogation Unit

From:

_____
Lawyer / Paralegal / Assistant

_____
Law firm

_____

_____
Address

_____ _____
Date **Number of Pages**

_____
Member Name

_____
Medicaid Number / DOB

_____
Date of Injury

Type of Injury

- ☐ **Auto**
- ☐ **Medical Malpractice**
- ☐ **Worker's Compensation**
- ☐ **General Liability**
- ☐ **Other**

_____
Insurance Company

_____
Address

_____ _____ _____
City **State** **Zip**

_____
Claim Representative

_____
Claim Number

_____
Claim Representative Phone Number

Notes

_____
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