

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

CASE NAME: _____

CASE NO: _____

ADDRESS: _____

SSN: _____

PHONE NO: _____

TYPE OF CASE: INITIAL APPLICATION SPECIAL NEEDS TRUST (SNT) CHANGE CANCELLATION

(Check all that apply) HIPPA 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) <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO

Is policyholder an Absent Parent? <input type="checkbox"/> YES <input type="checkbox"/> NO

Names of Covered Individuals in Household			Medicaid ID#	SSN	Relationship to Policy Holder (check one)					Date Of Birth
(Last)	(First)	(MI)			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? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Name _____ Condition _____

(Insurance Company Name) (_____) (Telephone Number)

(Address) (City) (State) (Zip)

(Policyholder Name) (Policyholder SSN) (Policy Number) (Policyholder DOB)

(Policy Effective Date) (Policy Termination Date)

(Employer Name) (Telephone Number)

(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 _____