APPENDIX F
Coordination of Benefits/Third Party Liability
Accident Information Report

Member Information:

Injured Member:	
Member's MHN ID:	**Telephone Number:**
Parent or Guardian:	

Accident Information:

Accident Date:			
Accident Type: ***Auto, Home, Work-related, etc.***			
Name of Person Responsible for Accident:			
Name of Insurance Company or Agent: **Address:** **Phone Number:**			
Policy No.:		**Accident Claim No.:**	
Name of Member's Attorney, if any: **Address:** **Phone Number:**			

☐ **For Information Only** ☐ **Request Casualty Extension (Attach copy of claim)**

Submitted by:_

Name Title

Provider Name and ID No.: _

Date: Telephone No.: _

Mail Original to: Georgia Department of Community Health
Subrogation Unit
c/o Health Management Systems, Inc.
900 Circle 75 Parkway, Suite 650
Atlanta, GA 30339
(678) 564-1163 office or (855) 467-3970 fax

DMA-312 (01/15)

THIS FORM MAY BE COPIED