

Tort Response Form

Client Information						
Today's date: / /			Client ID number:			
Date of birth: / /			Social Security Number:			
Last name:			First name:			
Information Provided By:						
Attorney <input type="checkbox"/>	Insurance <input type="checkbox"/>	Provider <input type="checkbox"/>	Recipient <input type="checkbox"/>	HHSC <input type="checkbox"/>	DSHS <input type="checkbox"/>	Other <input type="checkbox"/>
Name:			Telephone:			
Accident Information						
Date of loss: / /		Type of accident:				
Case comments:						
Attorney Information						
Name:			Contact name:			
Street Address:						
City:		State:			Zip Code:	
Telephone:			Fax number:			
Insurance Information						
Company name:			Contact name:			
Street Address:						
City:		State:			Zip Code:	
Adjuster's name:			Claim number:			
Policyholder:			Policy number:			
Telephone:			Fax number:			
Fax or Mail completed copy to:						
Texas Medicaid & Healthcare Partnership						
Tort Department						
PO Box 202948						
Austin, TX 78720-2948						
Fax: 1-512-514-4225						