

Tort Response Form

Client Information					
Today's date: / /			Medicaid 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"/>	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 78720-9981					
Fax: 1-512-514-4225					