Informational Claims Submission Form

You must complete either the Attorney Information section or the Insurance Information section.
You must submit only one form per client, even if you are submitting more than one informational claim.
*All of the fields marked with an * are required. Forms that are submitted without the required fields will be returned for correction.*

Date

Client Information

Name: (Last, First, MI)	
*Medicaid number:	Date of birth:

Accident Information

*Date of loss:	Type of accident:
Describe the injuries that the client received in the accident:	

Attorney Information *You must complete either this section or the Insurance Information section.*

*Name:	Contact name:	
Street address:		
City:	State:	ZIP Code:
*Telephone:	Fax:	

Insurance Information *You must complete either the Attorney Information section or this section.*

*Company name:	Contact name:	
Street Address:		
City:	State:	ZIP Code:
Adjuster's name:	Claim number:	
Policyholder name:	Policy number:	
*Telephone:	Fax:	

Provider Information

Name:	Telephone:	
Street address:		
City:	State:	ZIP Code:
NPI:		

Mail completed copy to:

Tort Department
PO Box 202948
Austin, TX 78720-2948
1-800-846-7307, Option 3