

SUPPLEMENT TO ASSIGNMENT OF PAYMENT - DHS 1125

SEPARATE FORMS MUST BE COMPLETED FOR EACH INDIVIDUAL INJURED IN AN ACCIDENT

<p>(1) Name of Injured</p> <p>_____</p> <p style="text-align: center;">Last Name First M.I.</p> <p>_____</p> <p>Address _____</p> <p>_____</p> <p>Case Name (if different from above) _____</p>	<p>(2) _____</p> <p style="text-align: center;">I.D. No. Case No.</p> <p>_____</p> <p>SSN _____</p> <p>_____</p> <p style="text-align: center;">Date of Birth Sex</p>	<p>(3) _____</p> <p style="text-align: center;">Date of Accident</p> <hr/> <p>(4) _____</p> <p style="text-align: center;">Application Date</p> <hr/> <p>_____</p> <p style="text-align: center;">Medical Elig Date</p>
<p>(5) Type of Accident:</p> <p><input type="checkbox"/> Auto <input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Moped <input type="checkbox"/> Worker's Compensation</p> <p><input type="checkbox"/> Motorcycle <input type="checkbox"/> Assault</p> <p><input type="checkbox"/> Pedestrian <input type="checkbox"/> Other: _____</p>	<p>(6) Medical Coverage</p> <p><input type="checkbox"/> Medicaid Fee for Service</p> <p><input type="checkbox"/> QUEST Plan: _____</p> <p><input type="checkbox"/> Other(s) Hosp. & Med. Ins. _____</p>	

(7) Provide a clear description of how the accident occurred. (Include actual time and location where accident occurred.)

(8) Describe the type of injury (e.g., broken arm, head injury, facial cuts or bruises, fracture of leg, etc. for additional space, use Sec. 19)

(9) Describe extent of injury (seriously, slightly, etc.)

(10) Recipient treated/seen by: (provide names of doctors, hospitals, laboratories, radiologists, pharmacists, dentists, etc.)

(11) Is recipient still under medical care for his/her injury? YES _____ NO _____

<p>(12) Person(s)/property owner(s) other than recipient who may be at fault:</p> <p>_____</p> <p>_____</p>	<p>Their Insurance Co. and Policy No.:</p> <p>_____</p> <p>_____</p>
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<p>(13) Does the recipient intend to file suit? YES _____ NO _____</p>	<p>(14) Date of settlement (if applicable)</p> <p>_____</p>
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(15) Does recipient have an attorney? YES ___ NO ____ . If yes, Name, address, and telephone number of recipient's attorney(s):

(16) Recipient had at the time of accident:

Free No-Fault Ins. Purchased No-Fault Ins. No Coverage

(Attach copy of HJUP-8 Certificate of Eligibility)

Name of Insurance Co., Policy No. and Claim No.

(17) Recipient was injured in own vehicle as a:

Driver or Passenger

Recipient was injured in/by another vehicle as a:

Driver of borrowed car _____

Passenger Name of vehicle owner and Insurance Co. and Policy No.

Pedestrian _____

Other (Please explain in Sec. 17) _____

Name of driver of vehicle and Insurance Co. and Policy No. (if different from above)

(18) Police Report: Yes Report No.: _____ None Available

(19) Other information (use blank sheet if additional space is needed)

(20) Worker's Name	(21) Date	(22) Section/Unit	(23) Phone No.
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