

Ohio Department of Medicaid
**INSTRUCTIONS FOR COMPLETING ODM 06613,
ACCIDENT/INJURY INFORMATION**

Recipient Data

1. Insert the county, case name, and case number.

Section I

1. List names of individuals involved in an accident or injury which required medical treatment.
2. List individuals "Recipient I.D. number, Date of Birth and Social Security Number.
3. Complete as much information regarding the accident/injury as available.

This information will be used in the recovery of Medicaid expenses from the individual(s) at fault.

The most essential information elements are:

- a. Date of accident/injury
- b. Date of birth
- c. Social Security Number
- d. Recipient I.D. Number
- e. Name and address of party at fault
- f. Name and address of insurance company of the party at fault
- g. Name and address of attorney representing the injured recipient, if an attorney has been secured
- h. Give a detailed explanation of the accident/injury. If "other" was checked, describe circumstances, for example: dog bite, malpractice, injury by a consumer product

Section II

1. Obtain the recipient/guardian's signature and date. Ensure the recipient understands that the information will be used to recover medical expenses as authorized by the Ohio Revised Code.
2. If the recipient has a telephone, enter the phone number.
3. The caseworker who assists in completion of this form must sign as a witness and date.

Distribution

Mail original to: Ohio Department of Medicaid
Program Integrity/HIPAA/TPL Section
P.O. Box 182410
Columbus, Ohio 43218-2410

Provide one copy to the recipient, If the IV-D Section originates the form, they should retain one copy and forward the other to the IV-A. If the IV-A originates the form, send the copy to IV-D.