Third Party Liability Indicator

(If you need more space to finish any section on this form, please use the back of this form) Date: _

Head of Household: (Last, First, MI) _____ SSN: _ Telephone No.: _____

I. MEDICARE INFORMATION

Name: (Last, First, MI) _____ Claim No.: _____

Part A Start Date: _____ Part A End Date: _____

Part B Start Date: _____ Part B End Date: _____

II. COMMERCIAL HEALTH INSURANCE INFORMATION

☐ New Policy ☐ Change Policy ☐ Terminate/Closed Policy ☐ Additional Policy ☐ Policy Ended Due to Leaving Job

Policyholder's Name: (Last, First, MI) _____ Date of Birth: _____

SSN: _____ Policy No: _____ Insurance Company Name: _____
Group No.: _____ Policy Start Date: _____ Policy End Date: _____

Insurance Address: _____

Insurance Telephone No.: _____ Employer/Union Name: _____

Employer/Union Telephone No.: _____

Family Members Covered:

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

Name: _____ SSN: _____

III. ACCESS TO EMPLOYER-SPONSORED HEALTH INSURANCE

If not currently insured, does any family member's employer offer health insurance? ☐ Yes ☐ No

Employer/Union Name: _____ Telephone No.: _____

Employer/Union Address: _____

IV. CONTACT

Mail or fax this form to:

MassHealth
Third Party Liability Unit, P.O. Box 9212
Chelsea, MA 02150
T: 1.888.628.7526 | F: 617.357.7604