



MISSOURI DEPARTMENT OF SOCIAL SERVICES
 MO HEALTHNET DIVISION
MO HEALTHNET ACCIDENT REPORT

Submit this form to notify the MO HealthNet agency of information you have regarding a MO HealthNet participant's accident or injury. Please send completed form to:

Department of Social Services
 MO HealthNet Division
 Attention: TPL Casualty/Tort Recovery
 P.O. Box 6500
 Jefferson City, Missouri 65102-6500

DO NOT send claims with this form. Your claims will not be processed for payment if attached to this form.

MO HEALTHNET PROVIDER IDENTIFIER		DATE (MM/DD/YY)
PROVIDER NAME	PROVIDER TAXONOMY CODE	DATES OF SERVICE
PARTICIPANT NAME		MO HEALTHNET NUMBER
DATE OF ACCIDENT/INJURY		APPROXIMATE TIME
TYPE OF ACCIDENT/INJURY <input type="checkbox"/> AUTO <input type="checkbox"/> WORK-RELATED <input type="checkbox"/> OTHER (EXPLAIN)		
ATTORNEY REPRESENTING PARTICIPANT		
RESPONSIBLE PARTY'S NAME		POLICY/CLAIM NUMBER
INSURANCE COMPANY NAME AND ADDRESS		
HAVE YOU FILED A LIEN? IF YES, PLEASE PROVIDE DETAILS (I.E., AMOUNT, SERVICE DATES, ETC.) <input type="checkbox"/> YES <input type="checkbox"/> NO		
REMARKS		

Please attach copies of relevant documents (i.e. letters from attorneys, insurance companies, etc.) If applicable.
 THANK YOU FOR YOUR ASSISTANCE.