# ACCIDENT REPORT

Submit this form to notify the MO HealthNet Division of information you have regarding a MO HealthNet participant's accident or injury. Attach copies of relevant documents (i.e. letters from attorneys, insurance companies), if applicable.
**Do not send claims with this form.** Your claims will not be processed for payment if attached to this form.
Send completed form to MHD.CostRecovery@dss.mo.gov or mail to MO HealthNet Division, Attention: Third Party Liability Unit, PO Box 6500, Jefferson City MO 65102-6500.

**Provider Information**

| Provider Name | Date |
|---|---|
| | |

| Provider Taxonomy Code | NPI |
|---|---|
| | |

**Participant Information**

| Participant Name |
|---|
| |

| MHD Identification Number | Date(s) of Service |
|---|---|
| | |

**Accident/Injury Information**

Type of Accident/Injury
☐ Auto
☐ Work Related
☐ Other
If Other, explain:

| Date of Accident/Injury | Approximate Time |
|---|---|
| | |

| Attorney Representing Participant |
|---|
| |

| Responsible Party's Name | Policy/Claim Number |
|---|---|
| | |

| Insurance Company Name |
|---|
| |

| Insurance Company Street Address | City | State | Zip |
|---|---|---|---|
| | | | |

Have You Filed a Lien? ☐ Yes ☐ No
If Yes, Provide Details (i.e., Amount, Service Dates, etc.)

Remarks