NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Medicaid & Long-Term Care
Incident Investigation Form

Pete Ricketts, Governor

Dear Medicaid Recipient:
Medicaid and Long-Term Care has received information that indicates that you may have been involved in an accident. Federal and State regulations require a determination to be made if anyone is liable to pay any or all of the medical bills for the injury. Please respond to ALL of the questions below regarding your particular accident/incident as the following information is needed in order to make a determination if there is any liable parties and process your medical claims.

Please return this form to:
Email: dhhs.medicaidcasualty@nebraska.gov OR Fax: 402-742-8354 OR
Mail: Nebraska Department of Health and Human Services, P.O. Box 95026, Lincoln, NE 68509-5026, Attn: Medicaid Casualty Unit
If you have questions, please call: 1-877-255-3092 Option 2

Patient's Name:		Phone Number:
Street Address:		
	City	*State* *Zip Code*
Medicaid Number:	Date of Injury:	
List of Injuries *(If more room is required, use the back of this form)*:		
Location Accident Occurred:		
Street Address	*City*	*State* *Zip Code*

Type of Injury: *(Complete section indicated per injury type)*

☐ Motor Vehicle Accident *Complete Section A*	☐ Injury on Business Property *Complete Section D*	☐ Dog Bite *Complete Section D*	☐ Other Accident or injury (Specify): ex ; medical malpractice, sports injury *Complete Section D and E*
☐ Pedestrian-Vehicle Accident *Complete Section A*	☐ Accident at Home *Complete Section D*	☐ Attorney hired *Complete Section E*	
☐ Work-Related Accident *Complete Section B*	☐ Accident in Another Home *Complete Section D*	☐ Assault *Complete Section C*	

Section A: Motor Vehicle Accident *(If more space is needed, please use the back of this form)*

Were you driving? ☐ Yes ☐ No	If not, driver's name?		Police Called? ☐ Yes ☐ No
How many vehicles involved?		Auto Insurance Company:	
Insurance Company Address:			
Insurance Company Phone No:		Policy/Claim Number:	
Name of Insurance Adjuster/Agent:		Policyholder's Name:	

Section B: Work-Related Injuries *(If more space is needed, please use the back of this form)*

Name of Employee:		Employer's Address:	
Employer's Phone Number:		Employer's Insurance Company:	
Insurance Company's Address:			
Insurance Company's Phone Number:		Policy/Claim Number:	
Name of Insurance Adjuster/Agent:			

Section C: Assault *(If more space is needed, please use the back of this form)*

Police Called? ☐ Yes ☐ No	Charges Pressed? ☐ Yes ☐ No		
Name of Assailant:		Assailant ordered to pay medical bills? ☐ Yes ☐ No	

Section D: Other *(If more space is needed, please use the back of this form)*

Property Owner/Business Name:			
Property Owner/Business Address:			
Owner/Business Phone Number:		Owner's Insurance Company's Name:	
Insurance Phone Number:		Policy/Claim Number:	
Name of Insurance Adjuster/Agent:		Policyholder's Name:	

Section E: Attorney Information ***(If applicable)***

Patient's Attorney:		Attorney's Phone Number:	
Attorney's Address:			

I certify that all the questions have been answered truthfully to the best of my ability
Failure to cooperate may affect Medicaid eligibility (471 NAC 3-004.10B)

Sign Here _____ **Date** _____

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