MISSOURI DIVISION OF MEDICAL SERVICES

ACCIDENT REPORTING FORM

TPL - 2
(Rev. 4/85)

TO: _____
County Director

_____
County Office

DATE: _____

LOAD NO.: _____

1. Name of Claimant: _____ If child, _____ *(Name of Payee)*
2. Medicaid Identification Number: _____
3. Date of Service: _____ 4. Provider: _____

(Please complete No. 5 through No. 7 and Appropriate Section based on type of accident.)

5. Date of Accident/Injury: _____ Type of Accident: ☐ Auto ☐ Work Related ☐ Other
6. Location of Accident/Injury: _____ *(Street Address)* *(City)* *(State)* *(Zip)*
7. Name & Address of claimant's attorney, if any: _____

SECTION I – WORK RELATED ILLNESS OR INJURY:

8. Employers Name at time of illness/injury: _____
9. Employers Address: _____ *(Street Address)* *(City)* *(State)* *(Zip)*
10. DEPT.: _____ 11. Accident Claim Number: _____
12. Employer's Ins. Co. , Name & Address: _____

SECTION II – AUTOMOBILE ACCIDENT:

13. Name of the police department accident report filed: _____
(If available, attach a copy of the accident report)
14. The claimant was a)driver b)passenger c)struck by the vehicle.
15. Name and address of owner of vehicle:

_____
(NAME) (Street Number) (City) (State) (Zip)

16. Name and address of driver of vehicle if (b) or (c) circled:

_____
(NAME) (Street Number) (City) (State) (Zip)

17. Name of insurance company of owner or driver of vehicle: _____
18. Policy Number: _____ 19. Accident Claim Number: _____

SECTION III – OTHER ACCIDENT:

20. Person who caused accident or owner of premises: _____
21. Insurance company covering premises or person: _____
22. Policy or Claim Number: _____ Briefly describe what happened: _____

RETURN TO:
Third Party Liability Unit
Division of Medical Services
P. O. Box 6500
Jefferson City, Missouri 65102-6500

_____
(Date)