Tort Response Form

Fax or mail a completed copy of this form to:

Texas Medicaid & Healthcare Partnership
Attn: Tort Department
PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-514-4225

A. Client Information

Client Name (*Last, First, M.I.*):	
Client ID Number:	Date of Birth:
Social Security Number:	Today's Date:

B. Information Provided By

☐ Attorney	☐ Insurance	☐ Provider	☐ Recipient	☐ DSHS	☐ HHSC	☐ Other

Name:	Telephone:

C. Accident Information:

Date of Loss:	Type of Accident:
Comments:	

D. Attorney Information

Name:	Contact Name:
Address: Number Street	Ste. No. City State ZIP Code
Telephone:	Fax:

E. Insurance Information

Company Name:	Contact Name:
Address: Number Street	Ste. No. City State ZIP Code
Adjuster's Name:	Claim Number:
Policyholder:	Policy Number:
Telephone:	Fax: