To:

County Medical Services Program
Attention: TPL Unit
1545 River Park Drive, Suite 435
Sacramento, CA 95815

County use only:

Initial of person mailed:_________

Date the form mailed:__________

(Keep the copy in the file)

County Medical Services Program (CMSP)
POTENTIAL THIRD PARTY LIABILITY NOTIFICATION

1. Have you used, or will you use, CMSP for your injury or illness? ☐ Yes ☐ No
2. Have you filed, **or will you file**, a lawsuit or insurance claim? ☐ Yes ☐ No

*If you answered **Yes** to one or both of the above questions, complete the following*:

3. Injury /illness occurred at: ☐ Home ☐ Work ☐ School ☐ Motor Vehicle ☐ On someone else's property ☐ Other___________________________________

Case name (first, middle, last)			Date of injury or illness *(DATE MUST BE PROVIDED. MM/DD/YYYY)*	
Address (number, street)	City	State	ZIP code	Social security number
Mailing address	City	State	ZIP code	Telephone number ( )

Injured Persons(s):

Name	Date of Birth	County Code	Aid Code	Social Security Number (If not available, CMSP or CIN #)

4. Have you filed, **or will you file**, a lawsuit? ☐ Yes ☐ No If yes, please provide the following information:

Attorney Name			Telephone number ( )
Mailing address	City	State	ZIP code

5. Is there insurance (other than CMSP) **covering you or anyone else** for this injury/illness (auto, homeowners, premise liability, accident) ☐ Yes ☐ No If yes, please provide the following information:

Insurance company			Telephone number ( )
Mailing Address	City	State	Zip code
Claims adjuster	Claim/policy number	Policy Number	

WORK RELATED INJURY

Have you filed an application for Workers' Compensation benefits? ☐ Yes ☐ No If yes, please provide the following information:

Employer at time of accident	Telephone number ( )	Workers' Compensation claim/case number	
Mailing address	City	State	ZIP code

DO NOT WRITE BELOW THIS LINE

COUNTY USE ONLY

Eligibility worker	Worker number	County	Telephone number ( )