

To: Anthem Blue Cross
 Attention: TPL Branch
 5151-A Camino Ruiz, Mail Stop CC-20D
 Camarillo, CA 93012

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 School On someone else's property
 Work Motor Vehicle Other _____

Case name (first, middle, last)			Date of injury or illness (DATE MUST BE PROVIDED.)	
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 ()
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