Notification to Louisiana Medicaid

Date: _____

TO: Louisiana Medicaid Trauma Recovery Unit
543 Spanish Town Road
Baton Rouge, LA 70802
FAX #: 225-342-1376 PHONE #: 225-342-8662

FROM: Medicaid Provider_____ Provider # _____

☐ **INTENT TO PURSUE DIFFERENCE***

The provider intends to pursue the difference between the Medicaid payment and the liable third party with regards to the accident/incident listed below.

☐ **RECEIPT OF DIFFERENCE***

Settlement funds from the liable third party have been received. Please advise if Medicaid has been fully reimbursed in regards to the accident/incident listed below.

☐ **RETURN OF PAYMENT TO LIABLE THIRD PARTY*** $_____

Regarding: _____ _____
Medicaid Recipient Medicaid ID or Soc Sec #

_____ _____
Date of Birth Parish of Residence

Date of Accident/Incident_____

Third Party Information:

Third Party_____ Contact Person_____
Address_____ Phone #_____
_____ Fax #_____
Policy/Claim #_____

Completed By: _____
Signature

Address_____
_____
Phone #_____
Fax #_____

*Pursuant to the Third Party Liability Provider Billing and Trauma Recovery Provisions at LAC 50:I.8341-8349 (Louisiana Register, Volume 34 Number 4)