INTRADEPARTMENTAL MEMORANDUM
MAD-MR: 15-26
DATE: 10/22/2015

TO: **ISD AND MAD STAFF**

FROM: **NANCY SMITH-LESLIE, DIRECTOR, MEDICAL ASSISTANCE DIVISON**
MARILYN MARTINEZ, DIRECTOR, INCOME SUPPORT DIVISION

THROUGH: **ROY BURT, BUREAU CHIEF, ELIGIBILITY BUREAU**

BY: **RICHARD McINTYRE, ELIGIBILITY BUREAU**

SUBJECT: **DELETE AND REMOVE FORM MAD 009 & MAD 606**

GENERAL INFORMATION

The following forms have been determined by the Forms Committee to be obsolete:

MAD 009 Third Party Liability Inquiry Form
MAD 606 Certificate for CMT Assistance Form
MADSP 606 Certificado De Asistencia De Transporte Médico Al Cliente Form

FILING INSTRUCTIONS

Please make the following replacements in the Medical Assistance Manual.

Delete and Remove - MAD 009 Third Party Liability Inquiry Form revised 1/18/13

Delete and Remove - MAD 606 Certificate for CMT Assistance Form revised 1/18/13
MADSP 606 Certificado De Asistencia De Transporte Médico Al Cliente Form revised 4/22/13

Please address questions to Doris Valdez at dorise.valdez@state.nm.us. or (505) 476-6816.

TPL INQUIRY FORM

(For HSD USE ONLY)
HEALTH INSURANCE COVERAGE INFORMATION

ISD Office	Worker Number	Worker 's Telephone Number	Recipient Telephone Number	Page 1 of ____ pages

Case Name	Social Security Number	Date

☐ TPL ☐ PERSONAL INJURY ☐ CSED

1. Are any of the following working and or members of a union?

Natural parents	☐ Yes	☐ No
Recipient or spouse	☐ Yes	☐ No
Absent parent	☐ Yes	☐ No
Step parent	☐ Yes	☐ No
New spouse of absent parent	☐ Yes	☐ No
Children	☐ Yes	☐ No

Name of Employed Person(s)	Date of Birth	Social Security Number
Address of Employed Person(s)		Telephone Number
Name of Employer/Union		
Address of Employer/Union		Telephone Number

Are UNION FUND BENEFITS or HEALTH INSURANCE available? ☐ Yes ☐ No If "Yes" complete the information below.

2. Are you aware of any health insurance or other third party resource that ☐ covers or ☐ may be available to any member of the family? (For example: private coverage, school insurance, military, veterans, etc.) If "Yes" complete the following:

INSURANCE INFORMATION - Policy I

Name of Health Insurance Company	Address	City	State	Zip Code

Name of Policy Holder/Clients/Relationship to Policy Holder	Date of Birth	Policy Holder Social Security No.	Insurance Co. Telephone Number
Is Policy Holder Medicaid Eligible? ☐ Yes ☐ No / Policy Number	Group Number	Group Name (Employer/Program)	Coverage Dates:

Members of Family Covered By Insurance (Policy I)

Name	Date of Birth	Social Security Number	DOE	COE

ABSENT PARENT SECTION

3. Is there an absent parent? ☐ Yes ☐ No If "Yes, complete the following

Name of Absent Parent	Relationship	Date of Birth	Social Security Number
Address of Absent Parent			Telephone Number

Children responsible for:
1. ____
2. ____
3. ____

Does a divorce or separation agreement or other court order stipulate:
Health insurance must be provided: ☐ Yes ☐ No ☐ Unknown
Payments for medical care? ☐ Yes ☐ No ☐ Unknown

PERSONAL INJURY SECTION

4. Has any member of the family been involved in an accident for which medical services were required? ☐ Yes ☐ No
Where did the accident occur?
☐ Automobile ☐ Commercial Property ☐ School
☐ Private Property ☐ Place of Employment ☐ Home
☐ Other ____

Type of Injury? ☐ Motor Vehicle Accident
☐ Slip & Fall ☐ Worker Compensation
☐ Result of Crime ☐ Other *(please explain)* ____

Description of Injury:

Injured Recipients Name	Date of Accident	Social Security Number

Name of Insurance Company	*Address*	*City*	*State*	*Zip Code*	Telephone Number

Name of Insured	Claim Number	Policy Number

Name of Lawyer	*Address*	*City*	*State*	*Zip Code*	Telephone Number

DISTRIBUTION: **White copy** - ISD Office; **Canary copy** - MAD TPL; **Pink copy** - ***Circle*** CSED Region I II III IV V VI VII

MAD 009 Revised 4/3/03

INSTRUCTION TO COMPLETE THE TPL INQUIRY FORM MAD 009 (Third Party Liability)

PURPOSE - The TPL INQUIRY FORM - MAD 009 is used to establish the availability of insurance coverage. Insurance coverage may be available through an employer, school insurance, military, veteran or through an absent parent. The MAD 009 is also used to identify individuals who have been injured through fault of someone else, where a law suit and/or settlement may be involved.

PROCEDURES - The following are instructions for each section to be completed. The MAD 009 form is designed for the Income Support Division Worker to obtain the required information from the recipient at the time of initial interview and when information changes.

Do not send form to MAD if TPL information is entered into ISD2. Keep original on file. You may review or print PF-IO for TPL.

For Personal Injury, fill out section 4, send to MAD, attention Personal Injury Section.

For CSED, fill out sections 1 and 3, send to CSED Regional office (pink copy).

ROUTING - Upon completion, the original will stay in case file, the canary copy will be forwarded to HSD/MAD-TPL unit. The pink copy will be sent to the appropriate CSED Regional office (circle the correct Region office).

RETENTION - 1 year, or as information changes.

INSTRUCTIONS - (Please refer to form)
At the top of the MAD 009 form right corner, please print and complete with requested information.

ISD Office	Worker Number	Worker Telephone Number	Recipient Telephone Number

Indicate the Recipient's Name, SS# and Date form was completed.

TPL

1. Indicate who in family is employed, obtain all information relating to the employer, including telephone number. If the recipient is currently enrolled in the insurance offered by the empoyer, indicate in INSURANCE INFORMATION all information relating to the insurance coverage.

2. INSURANCE INFORMATION - Must be completed whenever there is insurance coverage. Relationship to policy holder - Indicate the relationship of the recipient to the policy holder *(mother, father, step-parent, spouse).*

   To be completed at time of PR:
   DOE - Date of Medicaid Eligibility.
   COE - Category of Eligibility.

3. ABSENT PARENT SECTION
   If there is an absent parent responsible for health insurance coverage for the children, complete this section entirely. If one or more of the children applying for Medicaid has a different absent parent, a separate form must be completed.

4. PERSONAL INJURY SECTION
   Complete each question if any member of the family has been involved in an accident. "Accidents" are not limited to automobile accidents but can include workers' compensation claims, medical malpractice claims and other personal injuries. If an answer is not known, please write "unknown" or if an answer is not applicable, please write "NA" in the spaces provided. Give any information that is known about the injury in the space "Description of injury".

CERTIFICATE FOR CLIENT MEDICAL TRANSPORTAION ASSISTANCE

Date:		
Name:		
Address - No. & Street / P.O. Box / R. Rt.		
City	State	Zip Code

I, ______________________________, state that I do not have a relative, friend, neighbor, volunteer or public service organization who can take me to the doctor, clinic, dentist, or other medical service provider for free. The worker in the Income Support Division Office talked to me about free transportation. I told the worker that I did not have someone to take me to my medical appointments for free.

Signed: ______________________________
(Client or Guardian)

Witness: ______________________________

MADSP 606, Revised 4/22/13
Medical Assistance Division

CERTIFICADO DE ASISTENCIA DE TRANSPORTE MÉDICO AL CLIENTE

Fecha	
NOMBRE:	
Dirección de correo: Nombre y número de calle.	
Ciudad	Estado	Zona Postal

Yo, ______________________________, declare que no tengo un familiar, amigo, vecino, voluntario u organización de servicio público quien me pueda llevar gratuitamente al doctor, clínica, dentista, u otro proveedor de servicio público. El trabajador en la oficina de División de Asistencia Económica hablo conmigo sobre transporte gratuito. Yo le dije al trabajador que no tengo alguien que me lleve gratis a mis citas médicas.

Firmado: ______________________________
(Cliente o Guardián)

Testigo: ______________________________