

Joe Lombardo
Governor

Rique Robb
Interim Director



**DEPARTMENT OF
HUMAN SERVICES**
DIVISION OF SOCIAL SERVICES
Helping people. It's who we are and what we do.



Robert H. Thompson
Administrator

MEDICAL / INSURANCE SUBROGATION

**HMS – NV Casualty Unit
PO BOX 844648
Los Angeles, CA 90084-4648**

Date: _____

From: _____ Re: _____
District Office Case Name Case No.

Name of injured person if different from case name

Client or caretaker/guardian name/ phone number

Form Completed: By Mail On Phone In Person

Please check appropriate box(es):

Client was injured while in the custody of
a law enforcement agency YES NO

Agency Name: _____

Agency Address: _____

The injury was job related YES NO

Client received or is receiving Workmen's
Compensation YES NO

Date Began: _____

Date Ended: _____

Client has an injury that resulted from an
accident which is NOT job related YES NO

Client has received or is currently
receiving medical care for an accident/
injury where the legal case has already
been settled or all benefits have been
expended/ exhausted YES NO

ACCIDENT/ INJURY INFORMATION

Date Occurred: _____
(Month, Day, Year)

Approximate time: _____
(A.M./ P.M.)

Address and location _____

How accident occurred _____

Other parties involved _____

Is your accident/ injury case currently open? YES NO If NO, Date case closed: _____

Was a settlement made? YES NO Date: _____ Sum: _____

OTHER PARTY

APPLICANT

Name of Insured _____

Insurance company _____

Insurance company address _____

Policy number, if available _____

Attorney, if involved _____

Attorney's address _____

Attorney's phone number _____

A copy of the accident report Is attached Will be forwarded, when available
 Is unavailable because: _____

I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

Signature Print Name Title/ Relationship Date Telephone Number