



## Third Party Liability Indicator

Date: \_\_\_\_\_

Head of Household: \_\_\_\_\_ MassHealth ID No: \_\_\_\_\_ Telephone No.: (\_\_\_\_) \_\_\_\_\_  
(Last, First, MI)

(If you need more space to finish any section on this form, please use the back of this form.)

### 1. Medicare Information

Name: \_\_\_\_\_ Claim No.: \_\_\_\_\_  
(Last, First, MI)

Part A Start Date: \_\_\_\_\_ Part A End Date: \_\_\_\_\_

Part B Start Date: \_\_\_\_\_ Part B End Date: \_\_\_\_\_

Part C Carrier Name: \_\_\_\_\_ Start Date: \_\_\_\_\_ Part C End Date: \_\_\_\_\_

### 2. Commercial Health Insurance Information

☐ New Policy ☐ Change Policy ☐ Terminate/Closed Policy ☐ Additional Policy ☐ Policy Ended Due to Leaving Job

Policyholder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ MassHealth ID No. or SSN: \_\_\_\_\_ Policy No.: \_\_\_\_\_  
(Last, First, MI)

Insurance Company Name: \_\_\_\_\_ Group No.: \_\_\_\_\_ Policy Start Date: \_\_\_\_\_ Policy End Date: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Insurance Telephone No.: (\_\_\_\_) \_\_\_\_\_

Employer/Union Name: \_\_\_\_\_ Employer/Union Telephone No.: (\_\_\_\_) \_\_\_\_\_

#### Family Members Covered:

Name: \_\_\_\_\_ MassHealth ID No: \_\_\_\_\_

Name: \_\_\_\_\_ MassHealth ID No: \_\_\_\_\_

Name: \_\_\_\_\_ MassHealth ID No: \_\_\_\_\_

Name: \_\_\_\_\_ MassHealth ID No: \_\_\_\_\_

### 3. Access to Employer-Sponsored Health Insurance

If not currently insured, does any family member's employer offer health insurance? ☐ Yes ☐ No

Employer/Union Name: \_\_\_\_\_ Employer/Union Telephone No.: (\_\_\_\_) \_\_\_\_\_

Employer/Union Address: \_\_\_\_\_

Mail or fax this form to:

MassHealth

Third Party Liability Unit, P.O. Box 9212, Chelsea, MA 02150

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