Ohio Tort Recovery Unit
Operated by Public Consulting Group, Inc.

Ohio Tort Recovery Unit
Capital Square Office Tower
65 East State Street
Suite 1530
Columbus, OH 43215

Local: 614-242-1050
Fax: 614-242-1051
Email: ohtort@pcgus.com
https://cmts.pcgus.com/accident

Attorney Lead Questionnaire

1. Date of Incident/Accident:

____

2. Person(s) Injured (Medicaid Recipient):

____

3. What part of the body was injured?

____

____

4. Has a settlement been reached? ☐ Yes ☐ No

5. Name and address of person(s) at fault:

____

____

6. Does the person at fault have insurance coverage? ☐ Yes ☐ No
   If yes, give name, address, and telephone number of the insurance company (please include policy number/claim number):

____

7. Name, address and telephone number of your Insurance company (please include policy number/claim number):

____

8. Please complete the following recipient information:

   Medicaid Id: ____________________ Social Security Number____________________
   Date of Birth: ____________________

Is the recipient enrolled in a Medicaid HMO? If so, which one? ____________________

Pursuant to Ohio Rules of Civil Procedure, service upon a state agency is to be made upon the director or the attorney general. Those addresses are as follows:

Director, Ohio Department of Job and Family Services
c/o Office of Legal Services
30 E Broad Street, 31st Floor, Columbus, Ohio 43215

Attorney General of Ohio
c/o Collections Enforcement Section,
150 E Gay Street, 21st Floor, Columbus, Ohio 43215

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ASSIGNMENT / AUTHORIZATION

I hereby assign to the Ohio Department of Job and Family Services all claims against third parties, including Tortfeasors and insurance companies, who may be liable for any of my medical expense to the extent that such expense are paid by Medicaid. Further, I authorize any holder of medical, or insurance related information about me to release information for such claims to the Ohio Department of Job and Family Services.

I hereby authorize the Ohio Department of Job and Family Services to release any bills paid by Medicaid under Title XIX of the Social Security Act related to the accident / injury, I / my dependent sustained on or about____________________

These documents may be released to my attorney / agency representing the liable party responsible for this accident / injury.

The original or copy of this assignment / authorization will be valid until the above incident is resolved by negotiation and / or court settlement.

Recipients Signature: ________________________ Date: ________________________

Medicaid Recipient ID Number: ________________________ Relationship to Injured Party: ________________________

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