Appendix H-1

Identification of Potential Third-Party Claimants

IDENTIFICATION OF POTENTIAL THIRD-PARTY CLAIMANTS

A. PROGRAM PARTICIPANT'S INFORMATION

1. Name	Last	First	Middle Initial
2. Date of Birth	____/____/____ (MM/DD/YYYY)	**3. Social Security Number**	___ - ___ - ____

B. INFORMATION FOR PROGRAM PARTICIPANT'S COUNSEL

4. Does the Program Participant have Legal Counsel?	☐ Yes ☐ No	If Yes, complete Item 5. If No, skip to Section C	
5. Legal Counsel's Name	Last	First	Middle Initial

C. IDENTIFICATION

Instructions: Identify all actual or potential insurers and all known third-party claimants with subrogation or reimbursement interests related to the released injuries (pursuant to any applicable state law or contractual terms) that are not Governmental Payors.

☐ Uninsured

For each entity you list, provide all available information requested, as well as a front and back copy of your insurance card, if available.

Insurer/Plan Name	Policy/Plan Number(s). (Include copy of Insurance Card)	Dates of Coverage/ Eligibility	Policyholder/ Subscriber Name	Coverage Description (Primary/Secondary/ Supplemental)

Known Third-Party Claimants	Address	Description of Claim

D. SIGNATURE OF PROGRAM PARTICIPANT

I acknowledge and understand that Program Participants are required to identify all actual or potential insurers and all known third-party claimants with subrogation or reimbursement interests related to the released injuries (pursuant to any applicable state law or contractual terms) that are not Governmental Payors.

The signature hereto constitutes certification under penalty of perjury that the information provided in and with this Form is true and correct to the best of my knowledge, information and belief.

Signature		**Date**	____/____/____ (MM/DD/YYYY)
Printed Name	First / Middle Initial	Last	

IDENTIFICATION OF POTENTIAL THIRD-PARTY CLAIMANTS

E. SIGNATURE OF COUNSEL

I acknowledge and understand that Program Participants are required to identify all actual or potential insurers and all known third-party claimants with subrogation or reimbursement interests related to the released injuries (pursuant to any applicable state law or contractual terms) that are not Governmental Payors.

The signature hereto constitutes certification under penalty of perjury that the information provided in and with this Form is true and correct to the best of my knowledge, information and belief.

Signature			**Date**	_____/_____/_____ (MM/DD/YYYY)
Printed Name	First	Middle Initial	Last	