PRINT FORM RESET FORM

DHS Oregon Department of Human Services

SHARED SERVICES
Office of Payment Accuracy and Recovery

Oregon Health Authority

Non-Vehicle Related Personal Injury

State office use only:	Send original to Personal Injury Liens. Make copy for case record.				
	Program:	Branch:	Case number:	Caseworker name:	Worker phone:
	☐ Branch ☐ PIL		Injured person's prime no.:	Case name:	

1. Name and address of injured person:

2. Date of injury/accident:

3. Were you employed at time of accident? ☐ Yes ☐ No
Who was your employer?_____

4. Location/address where injury/accident occurred (include city and state):

5. Describe what happened and injuries received:

6. Did you receive wage loss benefits? ☐ Yes Amount: $_____ ☐ No
Workers compensation? ☐ Yes Claim number: _____ ☐ No

7. Have you filed a personal injury claim for damages? ☐ Yes ☐ No

8. Has the claim been settled or resolved? ☐ Yes Amount: $_____ Date settled: _____ ☐ No

9. Were your medical expenses covered by an insurance company other than Medicaid? ☐ Yes ☐ No
Are your medical expenses still covered by this insurance company? ☐ Yes ☐ No
Policy number: _____ Insurance company name:_____

10. Your attorney's name:_____ Phone number:_____
Attorney's address: _____
_____

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11. Did injury or accident happen at work?	12. Did injury or accident happen other than at work?
Name of employer:	Name of person/organization causing injury:
Address:	Address:
City/State/ZIP:	City/State/ZIP:
Phone number:	Phone number:

13. Insurance company handling claim.			
Name:		Policy number:	Claim number:
Address:		City/State/ZIP:	
Adjuster's name:	Adjuster's phone number:	Policy holder's name:	

I declare that the information I have given on this form is correct and complete to the best of my knowledge. I understand that to knowingly give false information or to withhold information may result in a fine, imprisonment or both. If I am unable to provide verification for any of the information on this form, I will authorize the Department of Human Services (DHS) or Oregon Health Authority (OHA) to contact persons or agencies to obtain verification.

Client's signature:	Date:	Client's phone number:

Purpose of form:

- To determine if alternative resources are available to meet medical and/or maintenance expenses incurred due to the accident/injury.
- To file a lien on any claim for damages resulting from the accident/injury.
- If you need help, contact your case worker.

Return to:

Personal Injury Liens
PO Box 14512
Salem Oregon 97309

Under Oregon law you must report all personal injury claims to us.

The Department of Human Services (DHS) and Oregon Health Authority (OHA) will not discriminate against anyone. This means DHS|OHA will help all who qualify. DHS|OHA will not deny help to anyone based on age, race, color, national origin, sex, sexual orientation, religion, political beliefs or disability. You can file a complaint if you think DHS|OHA discriminated against you because of any of these reasons.