

Ohio Department of Job and Family Services  
**NOTIFICATION OF THIRD PARTY (TORT) REQUEST FOR RELEASE**

In compliance with OAC 5101:3-26-09.1 (E), this form notifies ODJFS of a request for the release of financial/claim information for the purpose of filing a tort action made by:

<b>ATTORNEY/COMPANY</b>	
<b>ADDRESS</b>	
<b>TELEPHONE NUMBER</b>	
<b>DATE OF ACCIDENT/INCIDENT</b>	

**On behalf of Medicaid recipient:**

<b>LAST NAME</b>	
<b>FIRST NAME</b>	
<b>CRIS-E NUMBER</b>	
<b>MEDICAID BILLING NUMBER</b>	
<b>MCP ENROLLMENT DATE</b>	
<b>MCP DISENROLLMENT DATE</b>	

**Submitted by:**

<b>MCP NAME</b>	<b>MEDICAID PROVIDER NUMBER</b>
<b>MCP/TORT COORDINATOR</b>	<b>DATE</b>

<p>Ohio Tort Recovery Unit</p> <p>Health Management Systems 350 Worthington Road, Suite G Columbus, Ohio 43082 Phone: (888) 245-9019 Fax: (614) 242-1051</p>
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