

INSTRUCTIONS
DHS 1125 (Rev. 08/13)

**ASSIGNMENT OF PAYMENT, REPAYMENT AGREEMENT, AND
AUTHORIZATION & WAIVER FOR RELEASE OF INFORMATION**

PURPOSE:

The DHS 1125, Assignment of Payment, Repayment Agreement, and Authorization & Waiver For Release Of Information form shall be completed for each beneficiary injured in an incident, accident, or accident related case where a third party may be liable for medical expenses paid by the Department on behalf of the beneficiary. The purpose of this form is to allow the State and Federal government to recover paid medical expenses and to obtain patient records as necessary to accomplish this function.

GENERAL INSTRUCTIONS:

The DHS 1125 form must not contain any amendments, additions, attachments, or changes of any nature. **THE MESSAGE ON THE BOTTOM OF THE FORM MUST BE STRICTLY ADHERED TO.**

SPECIFIC INSTRUCTIONS:

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| 1. Name of Injured Beneficiary | Indicate first, M.I., and last name |
| 2. Date of Accident or Incident | Indicate month, day and year accident or incident occurred. |
| 3. Dated: _____ | Indicate city and state where form is signed. |
| 4. This _____ day | Indicate day when form is signed. |
| 5. Of _____, _____ | Indicate month and year when form is signed. |
| 6. Signature of Witness | Self-explanatory |
| 7. Signature of Adult Beneficiary, Guardian, or Representative | Indicate signature of adult beneficiary or if all members of the beneficiary household is under age 18, the individual whose name is on the case, shall sign the form. |
| 8. Printed Name of Witness | Indicate first, M.I. and last name of witness. |
| 9. Street Address | Indicate address of adult beneficiary, guardian or representative signing the form. |
| 10. Title or Relationship of Witness | Indicate title, (e.g., EW, physician, patient financial representative, social worker, etc.) or relationship to injured beneficiary, (e.g., adult daughter, mother, aunt, etc.). |
| 11. City, State, Zip Code | Indicate city, state and zip code of adult beneficiary, guardian or representative signing this form. |

DISTRIBUTION:

1. Original and one copy to (MQD/FO/TPL).
2. Copy to case record.
3. Copy to beneficiary.

**** If there are any questions regarding the completion of this form, please contact the Med-QUEST Finance Office.**