STATE OF HAWAII
Department of Human Services

Med-QUEST Division

SUPPLEMENT TO ASSIGNMENT OF PAYMENT - DHS 1125

SEPARATE FORMS MUST BE COMPLETED FOR EACH INDIVIDUAL INJURED IN AN ACCIDENT

(1) Name of Injured

Last Name First M.I.

Address

Case Name (if different from above)

(2) I.D. No. Case No.

SSN

Date of Birth Sex

(3) **Date of Accident**

(4) Application Date

Medical Elig Date

(5) Type of Accident:

- ☐ Auto
- ☐ Moped
- ☐ Motorcycle
- ☐ Pedestrian
- ☐ Bicycle
- ☐ Worker's Compensation
- ☐ Assault
- ☐ Other: _____

(6) Medical Coverage

- ☐ Medicaid Fee for Service
- ☐ QUEST Plan: _____
- ☐ Other(s) Hosp. & Med. Ins. _____

(7) Provide a clear description of how the accident occurred. (Include actual time and location where accident occurred.)

(8) Describe the type of injury (e.g., broken arm, head injury, facial cuts or bruises, fracture of leg, etc. for additional space, use Sec. 19)

(9) Describe extent of injury (seriously, slightly, etc.)

(10) Recipient treated/seen by: (provide names of doctors, hospitals, laboratories, radiologists, pharmacists, dentists, etc.)

(11) Is recipient still under medical care for his/her injury? YES _____ NO _____

(12) Person(s)/property owner(s) other than recipient who may be at fault:	Their Insurance Co. and Policy No.:
(13) Does the recipient intend to file suit? YES _____ NO _____	(14) Date of settlement (if applicable)

(15) Does recipient have an attorney? YES ____ NO ____ . If yes, Name, address, and telephone number of recipient's attorney(s):

(16) Recipient had at the time of accident:

- ☐ Free No-Fault Ins. **(Attach copy of HJUP-8 Certificate of Eligibility)**
- ☐ Purchased No-Fault Ins.
- ☐ No Coverage

Name of Insurance Co., Policy No. and Claim No.

(17) Recipient was injured in own vehicle as a:

- ☐ Driver or
- ☐ Passenger

Recipient was injured in/by another vehicle as a:

- ☐ Driver of borrowed car
- ☐ Passenger
- ☐ Pedestrian
- ☐ Other (Please explain in Sec. 17)

Name of vehicle owner and Insurance Co. and Policy No.

Name of driver of vehicle and Insurance Co. and Policy No. (if different from above)

(18) Police Report: ☐ Yes Report No.: _____ ☐ None Available

(19) Other information (use blank sheet if additional space is needed)

(20) Worker's Name (21) Date (22) Section/Unit (23) Phone No.