



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

Casualty/Personal Injury Lien Request

Pursuant to 62 P.S. §1409 and Pa. Code tit. 55, §259

All applicable sections must be completed or request cannot be processed.

CLIENT INFORMATION:

LAST NAME:	FIRST NAME:	MI:
CIS/MA ID #:	SSN:	
DATE OF BIRTH (mm/dd/yyyy):	DATE OF INCIDENT/INJURY (mm/dd/yyyy):	

TYPE OF INCIDENT (CHECK ONE):

<input type="checkbox"/> Assault	<input type="checkbox"/> Animal Bite	<input type="checkbox"/> Auto Accident
<input type="checkbox"/> Burn	<input type="checkbox"/> Slip and Fall	<input type="checkbox"/> Work Injury
<input type="checkbox"/> Product Liability	<input type="checkbox"/> Medical Malpractice	<input type="checkbox"/> School Injury
<input type="checkbox"/> Other (briefly explain) _____		
List body parts injured: _____		
Has client finished treating? <input type="checkbox"/> Yes <input type="checkbox"/> No Date released from treatment _____		

CLIENT'S ATTORNEY INFORMATION:

Law Firm:	Attorney Name:
Mailing Address:	
City:	State: Zip:
Telephone #:	Fax #:
Docket/Court Case #:	

1<sup>ST</sup> PARTY INSURANCE INFORMATION:

Company Name:	Adjuster Name:
Mailing Address:	
City:	State: Zip:
Telephone #:	Fax #:
Policyholder:	Claim #:

3<sup>RD</sup> PARTY INSURANCE INFORMATION:

Company Name:	Adjuster Name:
Mailing Address:	
City:	State: Zip:
Telephone #:	Fax #:
Policyholder:	Claim #:

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Fax completed form to: 717 772-6553