INSTRUCTIONS
Revision
DHS 1125 (Rev. 11/02)

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 recipient 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 recipient. 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:

1.	Name of Injured Recipient	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 when form is signed.
6.	______________________	Indicate year when form is signed.
7.	Signature of Witness	Self-explanatory
8.	Signature of Adult Recipient, Guardian, or Representative	Indicate signature of adult recipient or if all members of the recipient household is under age 18, the individual whose name is on the case, shall sign the form.
9.	Printed Name of Witness	Indicate first, M.I. and last name of witness.
10.	Street Address	Indicate address of adult recipient, guardian or representative signing the form.
11.	Title or Relationship of Witness	Indicate title, (e.g., IMW, physician, patient financial representative, social worker, etc.) or relationship to injured recipient, (e.g., adult daughter, mother, aunt, etc.).
12.	City, State, Zip Code	Indicate city, state and zip code of adult recipient, guardian or representative signing this form.

DISTRIBUTION:

1. Original and second copy to (MQD/FO/TPL).
2. Third copy to case record.
3. Fourth copy to client.

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