

Ohio Department of Medicaid  
**TORT SUMMARY STATEMENT**  
**(for use by Medicaid serving Managed Care Plans (MCPs))**

MCP Name	Medicaid Provider Number
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In accordance with paragraph (A)(4) of rule 5101:3-26-09.1 of the Ohio Administrative Code, this form notifies the Ohio Department of Medicaid, or its designated entity, that financial/claim information was released to:

Name		
Address		
City	State	Zip Code

Because of a tort action on behalf of Medicaid recipient:

Last Name		First Name	
CRIS-E Number	Medicaid Billing Number	Social Security Number	
MCP Enrollment Date		MCP Disenrollment Date	

The MCP notifies Medicaid of the following:

Total Number of Tort Related Claims Released	
Inclusive Dates of Service to	
Total Amount Billed By Provider(s) \$	Total Amount Paid By MCP \$
<div style="display: flex; justify-content: space-between; align-items: center;"> <span>(please check)</span> <input type="checkbox"/> Final             <input type="checkbox"/> Interim           </div>	

The undersigned certifies that the above information is complete and accurate:

MCP/TORT Coordinator	Date
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