Casualty Referral Form

Please print the following information.	
Name of Recipient:	
Address of Recipient:	
Type of Injury:	
Date of Injury:	
Name of Recipient's Attorney:	
Name of Alleged Liable Third Party:	
Narrative Description of Injury Circumstances:	
Do you wish to remain anonymous? Yes If No, please provide the following information:	No
Your Name:	
Your Address:	
	Phone Number:

Mail this completed form to:

DSS Office of Recoveries & Fraud Investigations Attn: Medical Resources Recovery 700 Governors Drive Pierre, SD 57501-2291