pennsylvania
DEPARTMENT OF HUMAN SERVICES

Statement of Claim Request Form

DECEDENT'S NAME:	
DECEDENT'S LAST KNOWN ADDRESS: (Prior to entering nursing home.)	
	(CITY, STATE, ZIP CODE)
DECEDENT'S SOCIAL SECURITY NUMBER:	/ /
DECEDENT'S DATE OF BIRTH:	
DECEDENT'S DATE OF DEATH:	
GROSS AMOUNT OF DECEDENT'S ESTATE: (Written documentation must be included.)	
PERSONAL REPRESENTATIVE'S NAME:	
PERSONAL REPRESENTATIVE'S ADDRESS:	
	(CITY, STATE, ZIP CODE)
PERSONAL REPRESENTATIVE'S PHONE NUMBER:	( )
ESTATE ATTORNEY'S NAME:	
ESTATE ATTORNEY'S ADDRESS:	
	(CITY, STATE, ZIP CODE)
ESTATE ATTORNEY'S PHONE NUMBER:	( )
ESTATE ATTORNEY'S FAX NUMBER:	( )
ESTATE ATTORNEY'S EMAIL ADDRESS (OPTIONAL):	

SEND TO:

DEPARTMENT OF HUMAN SERVICES
DIVISION OF THIRD PARTY LIABILITY
ESTATE RECOVERY PROGRAM
P.O. BOX 8486
HARRISBURG, PA 17105-8486

ESTATE RECOVERY HOTLINE
1-800-528-3708
FAX: (717) 772-6553