

SUBROGATION FORM

EMPLOYEE: _____ SSN: _____

EMPLOYER: _____ PATIENT: _____

Medical Claims Management Corporation has received claims for a condition which may have been caused by another person, product or property hazard. Your Group Health Plan contains a subrogation provision which entitles the Plan to recover monies paid for a condition caused by a responsible party. If the circumstances of claim(s) paid give the Plan an opportunity for reimbursement, we will seek repayment from any other insurance coverages you may have or responsible parties and/or their insurance coverages. For example, when insurance coverage such as underinsured motorists' coverage, uninsured motorists' coverage, homeowner's insurance or other liability policies is available, the Plan will seek repayment from such sources for medical bills paid by the Plan. Please answer the following questions and return this form to our office.

All claims related to this accident or incident will remain pended until this form and a copy of the complete accident report (indicating any violations issued) are returned to our office.

1. Date of the accident/incident: _____

2. Describe the injuries caused by this accident: _____

3. Where did the accident/incident occur? _____

4. List the name(s) and relationship to you of the person(s) involved in the accident/incident, including yourself. _____

5. Did you report the accident/incident to the police? Yes _____ No _____
If so, attach a copy of the police accident/incident report. The report must indicate any violations given, as well as which party was contributory.

6. Do you believe any person, product or property hazard caused or contributed to your injury or illness? Yes _____ No _____
A. If yes, state the other party's name, address and telephone number.

B. Does this party have insurance coverage? Yes _____ No _____
If yes, give the name of the insurance company, name of the policyholder, complete mailing address, telephone number, policy number and claim number.

C. If no, (yourself and/or dependent at fault) give the name of your insurance company, name of the policyholder, complete mailing address, telephone number, policy number and claim number.

7. Have you retained an Attorney? Yes _____ No _____

A. Please provide your Attorney's name, address and telephone number.

B. Have you or do you intend to file suit? Yes _____ No _____

8. Have you received any settlement monies from this accident or incident? Yes _____

No _____ If so, give the amount of settlement monies received and the person/company from whom you received the settlement. _____

Your signature below indicates that the information given is correct and that you understand and agree that the Group Health Plan has the right to recover any benefit monies paid due to the accident/incident described herein through the subrogation provision of the Group Health Plan.

Date Employee Signature

Date Dependent Signature

Thank you for your cooperation. If you or your representative should have any questions regarding any of the above, please feel free to contact our office at any time. Please return the completed subrogation form to the address given below.

Medical Claims Management Corporation
ATTN: Subrogation Dept.
PO Box 12995
Charlotte, NC 28220-2995
(704) 525-1473 or 800-334-0609