Dear Insured:

We have received notice that you or your dependent required medical treatment that may be due to an accident or injury. Please refer to the enclosed explanation of benefits (EOB) for information pertaining to this claim. The claim is currently pending your completion of the attached form so that we may process these charges properly.

When referring to your group plan under the section titled "Subrogation", you will see that your Employer Sponsored Plan is entitled to reimbursement and recovery of benefits paid due to an accident or injury where a third party is involved.

The enclosed form provides HealthFirst with a written guarantee that you will reimburse the Plan for all benefits paid on this accident or injury, should you receive payments for medical expenses. By furnishing us with this guarantee, we can be of more immediate service to you by paying benefits as they become due.

Please complete and return the enclosed form to HealthFirst. A return envelope has been enclosed for your convenience. If you have questions concerning these forms, contact Client Services at 1-800-477-2287 or at 903-581-2600.

Regards,

HealthFirst
Claims Department
P.O. Box 132317
Tyler, TX 75713-2317

*****Please type or print*****

Patient's Name: ____

Date of Service (Refer to enclosed EOB):______________________________

Nature of injury or illness (i.e. broken arm, whiplash, etc.)**:**____________________

____

If this is not an injury/accident, please state briefly whether this is **ongoing pain** or **sudden instance** of pain.

Date of accident/injury: ______________________________________

Location of accident/injury (you may just specify "home" if that's where accident occurred)

Street Address: ______________________________________

City, State, Zip: ______________________________________

Was this accident /injury related to work? **Yes** **No**

Describe what happened: **(**i.e. auto accident, fell off ladder, etc.) __________________________

____

What other type of insurance may be involved? (i.e. auto, homeowners, business liability, etc.)

____

Please provide other insurance information:

For auto accidents please provide auto insurance information for ALL parties involved regardless of whose fault the accident might be.

Insurance Company: ____

Adjustor's Name:____

Claim Number: ____

Phone Number:____

Mailing Address: ____

Have you retained an attorney? **Yes** **No**

If you answered "Yes" please provide your attorney's information:

Name of Law Firm: ______________________________________

Name of Attorney: ______________________________________

Phone Number: ______________________________________

Mailing Address: ______________________________________

In the event you answered "No", and then later decide to retain an attorney, please notify HealthFirst TPA and provide the information requested above.

Did the **Police** investigate the Accident? **Yes** **No** If **yes,** a **copy** of the **police report** is required.

I, ____________________, do hereby certify that should any reimbursement be made by a third party or another insurance carrier, that____________________(Employer) will be reimbursed for all benefits paid related to this accident or injury.

I, ____________________, do hereby certify that should any reimbursement be made by a third party or another insurance carrier, that____________________(Employer) will be reimbursed for all benefits paid related to this accident or injury.

Employee Name (Print Please) ______________________________________

Employer:____

Group Number **(**Refer to enclosed EOB): ____________________________

Injured Person's Signature (if **18 or older**) ______________________________ **Date** ______________