



Claim Recovery Specialists

163 Bay State Drive • Braintree, MA 02184 • (781) 535-5600 • Fax (781) 535-5656

The claims administrator for your benefit plan has received a medical claim for you or a dependent. We, The Phia Group, are the legal administrators who pursue subrogation and/or reimbursement claims on behalf of your benefit plan. The purpose of this letter is to ensure that no other party is responsible for payment of this claim.

In accordance with the terms of the plan document, your cooperation is required in providing the requested information. Please print this form and return this information to: **The Phia Group, LLC, 163 Bay State Drive, Braintree, MA 02184** within 20 days.

If you have any questions or need assistance, please call us **toll-free** at **888-986-0080** between the hours of 9:00am to 8:00pm EST Monday - Friday. Thank you for your anticipated cooperation and timely reply.

Sincerely,
The Phia Group

Claim Administrator: _____ Company Name: _____

Date of Treatment: _____ Patient: _____

Treatment For: _____ Member: _____

SECTION 1:

IF THE TREATMENT WAS DUE TO ONE OF THE FOLLOWING, MARK ONE
(IF NOT APPLICABLE PROCEED TO SECTION 2)

- Motor vehicle accident
- Work accident (workers' compensation, etc.) Did you file a WC claim? Yes No
- Slip and fall (NOT at your home)
- Other party responsible (malpractice, animal bite, etc.) specify: _____
- School sport related injury and a claim was filed with another insurance company

SECTION 2:

IF THE TREATMENT WAS DUE TO ONE OF THE FOLLOWING, MARK ONE

- Injury at home (injury in YOUR own home)
- Sport related injury (recreational, etc.) and there is no other insurance coverage
- Ongoing condition (chronic back pain, arthritis, etc.)
- Other – please describe below:

BRIEFLY DESCRIBE THE TREATMENT DETAILS AND SIGN BELOW

Signature: _____ Date: _____

Home/Cell Phone: (____) _____ Work Phone: (____) _____

SECTION A: INCIDENT INFORMATION

Please Describe the Incident Below:

Date of incident: _____
Type of incident: _____
Type of injuries sustained: _____
Are you still being treated? _____
Did you file a claim (other than with your Plan)? _____
If yes, with whom? _____
Incident Details and Location (Street, City, State, etc.):

SECTION B: MOTOR VEHICLE ACCIDENT

MVA Type: Single Vehicle: _____ Multiple Vehicle: _____
Names of other people injured in accident:

Police report filed? Yes No **Please Enclose Copy of Report**
Who was at fault? _____
Who, if anyone, was cited? _____
Did you receive a settlement? _____ If so, when? _____

Your Automobile Insurance Information:

Driver Name: _____
Owner Name: _____
Owner Address: _____
City _____ State _____ Zip _____
Owner Phone #: _____
Insurance Company: _____
Adjuster Name: _____
Adjuster Phone #: _____
Insurance Address: _____
City _____ State _____ Zip _____
Claim #: _____
Policy #: _____

Responsible Party's Automobile Information:

Name: _____
Address: _____
City _____ State _____ Zip _____
Phone #: _____
Insurance Company: _____
Adjuster Name: _____
Adjuster Phone #: _____
Insurance Address: _____
City _____ State _____ Zip _____
Claim #: _____
Policy #: _____

SECTION C: WORKERS' COMPENSATION CLAIM

Did you notify your employer of your injury/accident? Yes No
Did you file a Worker's Compensation (WC) claim? Yes No
If yes, was your claim approved? Yes No
If no, are you still pursuing a claim with the WC carrier? Yes No

SECTION C: CONTINUED

Employer's Name: _____
Employer's Address: _____
City _____ State _____ Zip _____
Phone #: _____
WC Insurance Company: _____
Adjuster Name: _____
Adjuster Phone #: _____
WC Insurance Address: _____
City _____ State _____ Zip _____
Claim #: _____
Policy #: _____

SECTION D: OTHER INSURANCE CLAIM

Homeowners, Medical Malpractice, Slip and Fall or other Insurance Claim

Name of Responsible Party (RP): _____
Address: _____
City _____ State _____ Zip _____
Phone #: _____
RP Insurance Company: _____
Adjuster Name: _____
Adjuster Phone #: _____
Insurance Address: _____
City _____ State _____ Zip _____
Claim #: _____
Policy #: _____

SECTION E: ATTORNEY INFORMATION

Attorney Name: _____
Address: _____
City _____ State _____ Zip _____
Attorney Phone #: _____
Attorney Fax #: _____
Attorney Email: _____

**SECTION F: PLEASE SIGN AND DATE BELOW.
RETURN IN THE ENCLOSED ENVELOPE.**

I hereby acknowledge and agree to the terms of my Plan's subrogation, reimbursement and/or third party recovery provision, which provides that the Plan has subrogation and/or reimbursement rights to the medical claims paid on my behalf. I acknowledge that I have an obligation to cooperate with the Plan and provide the Plan with information pertinent to protecting these Plan rights. I authorize my Plan and The Phia Group to release information regarding any claims in accordance with the Plan's subrogation and/or reimbursement rights. Furthermore, I hereby authorize any medical provider, my lawyer or agent, or any other person or corporation to release any and all medical information relating to this incident to The Phia Group.

Signature of Plan Member: _____ Date: _____
Home/Cell Phone: _____ Work Phone: _____
Email: _____