RE: Member: ID#:
Date of Service:
Reason:

Dear Member:

We represent your employee health plan that provides administrative services for your Medical Benefits. This plan includes a "right to recovery" provision. This provision, which helps to control the cost of your benefits program, permits recovery of benefits advanced as the result of the actions of responsible third parties.

Information provided with your claim indicates that the expense may have resulted from injuries or illnesses involving a third party (workers compensation, motor vehicle accidents, slips or falls on private property, food poisoning, dog bites or assaults). Under the plan provision mentioned above, there is no coverage for such expenses to the extent that they are reimbursable as the result of a third party liability action. However, the plan does allow temporary benefits to process on claims pending the result of a third party liability action. In order for benefits to be paid on an ongoing basis, the following information must be submitted to our office within 30 days of the date of this letter.

Reimbursement Lien Agreement:
The enclosed agreement must be signed indicating your agreement to reimburse your Health Plan should there be a recovery realized from a negligent third party.

General Liability/Motor Vehicle Accident:
The enclosed questionnaire must be completed in detail. If the questions are not applicable to your claim, please provide a statement with details of this accident and any applicable insurance information. This will enable us to determine whether your claim would be subject to the right of recovery provision, and if so, what actions should be taken to assure that your claim is processed in accordance with this plan provision. Failure to complete this form may result in the denial of your claim. Claims denied for more than 180 days may not be eligible for reimbursement.

Authorization to Release Medical Records:
The enclosed Authorization to Release Medical records must also be signed giving HMA, LLC, permission to release claim and medical information to your attorney of to other insurance companies.

Return all forms completed and signed via fax 866-298-9842 or mail to:

HMA, LLC
TPL Department
PO Box 22009
Tempe, AZ 85285

Should you have any questions regarding the right to recovery provision or this letter, please contact HMA, LLC, at (888) 811-8944.

Sincerely,

TPL Coordinator

Enclosures Lien and Agreement
Third Party Liability Questionnaire
Authorization to Release Medical Records.

Patient:
Our File No:
Date of Treatment:
Type/Reason:

Dear Member:

Recent claims submitted by your healthcare provider indicate that you have received services that may relate to an injury or accident that occurred as the result of another party. Please take a few moments to complete the enclosed form that will assist us in confirming the cause of your injury or accident.

1. If your injury or accident was not a result of another party, please complete Section A of the attached questionnaire, sign it, and send it back. We require your signed report to close our research and process your claims.

2. If your injury or accident was a result from another party, please complete all applicable parts of section A, B, C, and D then send it back.

This information is crucial to the accurate and timely processing of your healthcare claims.

Please complete the enclosed form and return to us as within 10 days or receipt.

If you need assistance or have any questions regarding how to complete these forms, please contact our Recovery Department at (888) 811-8944.

Sincerely,

Recovery Department

SECTION A (For; Falls, Assaults, Accidents, Dog Bites, Work Comp, Other or No TPL)

1. **Please give the date of service/injury/treatment**_____

   Please give the type of treatment or injury_____

2. **Was your medical treatment the result of Third Party? Please circle**: YES or NO

   If No, Please explain reason for medical treatment, then go to the bottom of this page to item #7:

   _____

   _____

3. **Where did the injury or incident occur?** _____

4. **Was this at a place of:** **Please circle**: business or residence

   If Yes, please state:
   At fault parties Name_____

   Location of Business or Residence, _____

   Name of Homeowners or Property Insurance _____

   Policy & Claim # _____*Phone#* _____

5. **Did your injury occur at work?** **Please circle**: YES or NO

   If Yes, please state:

   Company Name/Place of Employment_____

   The name of the worker compensation insurance company: _____

   The claim Number: _____

   Name and phone number of contract person: _____

   Have you, or do you plan to; retain an attorney as the result of this incident / accident?

   Please circle: YES or NO

   If Yes, What is the attorney's name & phone_____

7. **The foregoing is true and correct to the best of my knowledge:**

   _____ _____

   Patient's Signature (or Legal Guardian) **(Date)**

   Phone (Home) (____) _____ Phone (Work) (_____) _____

Member Name: **Member ID:**

SECTION B (FOR MOTOR VEHICLE ACCIDENTS)

1. **Please give the date of the accident:**_____

2. **Briefly explain what happened**:_____
_____
_____

3. Patient was: Driver_____ Passenger _____Pedestrian_____?

4. Where other family members involved? **Please circle**: YES or NO
If Yes, please list their names: _____

5. Who owns the vehicle in which you were driving and/or riding in? _____

6. Name of the auto insurance company?_____

   Has a claim been filed? _____If Yes, Claim #_____

   What is the name & phone # of the insurance company?_____

   What is the insurance policy number?_____

   Is there Personal Injury Protection Coverage? _Yes_____No_____Unknown__

   Attach a copy of the police report if available.

If another vehicle was responsible for this accident please completed the following:

7. Name of the auto insurance company?_____

   Has a claim been filed? _____If Yes, Claim #_____

   What is the name & phone # of the insurance company?_____

   What is the insurance policy number?_____

   Is there Personal Injury Protection Coverage? Yes_____No_____Unknown__

   Attach a copy of the police report if available.

8. **Have you, or do you plan to, retain an attorney as the result of this accident?**
Please circle: YES or NO

   If Yes, what is the attorney's name and telephone number:_____
_____

The foregoing is true and correct to the best of my knowledge:

_____ _____
Patient's Signature (or Legal Guardian) **(Date)**

Phone (Home) (____) _____ **Phone (Work) (_____)** _____

Member Name: **Member ID:**

SECTION C

**********LIEN AND AGREEMENT**********

I acknowledge that I have an obligation to reimburse my group health plan whenever someone else (including my own insurance company) compensates me for this incident/accident.

I will reimburse the Plan for any benefits it advanced with regard to the incident/accident, up to the full amount of compensation received, regardless of how that compensation may be characterized. I will reimburse the Plan even if I believe I was not fully compensated for my loss. I understand that the reimbursement will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion.

I authorize my insurance carrier, attorney or other party in possession of such compensation to pay the reimbursement directly to the group health plan, in care of HMA, LLC. If I am not the claimant I certify that I am authorized to sign this form on behalf of the claimant and acknowledge that all references to me above also include the claimant.

_____ _____

Signature of claimant or person authorized to sign on claimants behalf Date

Print Name: _____

Relationship to claimant: _____

Member Name: **Member ID:**

SECTION D

Authorization to Release Medical Records

I authorize and direct HMA, LLC, to release all, by facsimile and/or mail, any such medical records to any insurance company or attorney's office, and/or their authorized representatives. This information will be used for determining health benefits and/or eligibility.

Medical records shall include all past, present, or future medical information or knowledge of medical information, medical reports, physical examination reports, hospital reports, laboratory reports, or x-ray reports relating to me or my health.

This Authorization shall be valid for thirty-six (36) months from the date hereof.

A photocopy and/or facsimile of this Authorization shall be as valid as the original.

_____ _____

Member Signature Date

_____ _____

Type or Print Name Social Security #

Member Name: **Member ID:**