

# SUBROGATION FILE REFERRAL FORM

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## HEALTH INSURANCE SUBROGATION

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Date: \_\_\_\_\_

Company: \_\_\_\_\_ Claim Adjuster: \_\_\_\_\_

Company Address: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Ext.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Claim Adjuster's E-Mail: \_\_\_\_\_

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Full and Correct Name of Carrier or Employer Plan Paying Benefits: \_\_\_\_\_

Insured/Employer/Plan Sponsor: \_\_\_\_\_ Contact: \_\_\_\_\_

Insured/Employer/Plan Sponsor Address: \_\_\_\_\_

Insured/Employer/Plan Sponsor Phone: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Loss Location: \_\_\_\_\_

Claim No.: \_\_\_\_\_ Claimant/Beneficiary/Injured Party: \_\_\_\_\_

Claimant/Beneficiary/Injured Party Address: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Type of Plan (ERISA-Employer Sponsored, Private, Occupational Accident): \_\_\_\_\_

Total Benefits Paid: \_\_\_\_\_ Medical: \_\_\_\_\_ Indemnity (Lost Wages): \_\_\_\_\_

Death: \_\_\_\_\_ Vocational: \_\_\_\_\_ Other: \_\_\_\_\_

SIR/Retro/Deductible: \_\_\_\_\_ Reserves: \_\_\_\_\_

Facts of Accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

State in Which Plan Administrated: \_\_\_\_\_

Potential Third Party: \_\_\_\_\_

Third Party's Liability Carrier: \_\_\_\_\_ Policy Limits: \_\_\_\_\_

Claimant's/Beneficiary's/Insured's Attorney: \_\_\_\_\_

Claimant's/Beneficiary's/Insured's Attorney's Address: \_\_\_\_\_  
\_\_\_\_\_

Attorney's Phone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Suit Filed? No \_\_\_\_\_ Yes \_\_\_\_\_ Where Was Suit Filed? \_\_\_\_\_

Summary of Recovery Efforts Made to Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Proposed Fee Arrangement: \_\_\_\_\_

Special Handling Instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note: Please include a copy of the complete Plan, if possible, and, at a minimum, the relevant Plan language regarding subrogation, reimbursement, and discretion of Plan fiduciary.**