Subrogation Questionnaire

Our review process indicates that you may have received healthcare services related to an accident. Completing the below questionnaire will help us determine if another party is responsible for claims reimbursement.

1. Have you been involved in an accident that required medical care?
   Yes ____ No ____
   If no, please sign and return this questionnaire so that we may update our files. If yes, please continue.
2. What was the date of accident? _____
3. Was this accident work-related?
   Yes ____ No ____
   If **no,** please skip to question #5.
   Employer Name, Address and Phone #:

4. Are you currently represented by an attorney?
   Yes ____ No____
   If yes, please provide attorney contact information.
5. Did your accident involve a Motor Vehicle?
   Yes ____ No ____
6. If this was not a Motor Vehicle accident, has someone else claimed responsibility for the accident? (For example: A slip and fall that occurred at a commercial property)
   Yes ____ No ____
7. Please describe the accident and how it happened:

8. Responsible person/party's Insurance Company.
   Name, Address and Phone Number:

Claim Number:

Adjuster's Name:

To the best of my knowledge, the information on this questionnaire is true and accurate.

Signature Date Phone Number

Please send the completed form to the following address:
Bright Health Medicare Advantage - Claims
P.O. Box 853960
Richardson, TX 75085-3960

For questions, call Bright Member Services (844) 202 - 4463 (TTY: 711)
8 am – 8pm local time, Monday through Friday, except federal holidays.