

## 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:

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Adjuster's Name:

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

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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 - 4793 (TTY: 711)  
8 am – 8pm local time, Monday through Friday, except federal holidays.**