**75 E. Santa Clara Street, Suite 950**
**San Jose, CA 95113**
**(408) 937-3600**

Claim: _____

Patient: _____

Provider: _____

Date of service _____

Dear Member:
Was the accident/injury received by the above mentioned patient caused by a third party?
_____ Yes _____ No

If no, please indicate the nature of the accident/injury:
_____
_____
_____
_____

Signature: _____

If yes, please indicate location, date, and time of occurrence:
_____
_____
_____
_____

Does a third party have insurance covering the medical expenses?
_____ Yes _____ No

If there is third party coverage, please provide the following:
Name of insurance carrier: _____
Address: _____
Phone Number: _____
Policy Number: _____

If covered by a third party, please read, sign, and return the attached assignment for our records. If no third party is involved, only complete this page.

Thank you in advance for your cooperation.

Sincerely,

TPL Coordinator