

SUMMERLIN

LIFE & HEALTH INSURANCE COMPANY

Date: __«Date_Sent»_____

Dear Summerlin Life & Health Member:

The enclosed letter and incident report are designed to help us to determine if your injury is due to the fault of another party. **We ask that you please fill out the incident report as completely as possible and mail it to Summerlin Life & Health, P.O. Box 379032, Las Vegas, NV 89137. Or fax it to Cyndy at 866-298-9842.**

**Please do not return pages 1 & 2 of the TPL Questionnaire, these are for your information only.

Subrogation is the legal and contractual right for Summerlin Life & Health to be reimbursed by a third party for the medical bills that we have paid on your behalf. If you or your covered dependent is injured at the fault of another party, we will fully investigate and pursue recovery for any funds payable by the responsible third party. Some examples of when subrogation may apply are:

- Automobile, taxi, bus and airplane accidents
- Trip, slip and fall accidents
- Work related injuries
- Medical malpractice

When we receive a bill from your provider for treatment involving the following diagnosis; but not limited to:

- Fractures
- Back or head injuries
- Burns
- Severe contusions and lacerations
- Any unexplained trauma

We need to investigate the cause to identify if there is third party involvement. While this request may take a moment of your time, your kokua is appreciated so claims can be processed in the most efficient manner.

If you need assistance or have any questions regarding how to complete these forms, please contact our Customer Service Department at: 808-951-4645. Or Cyndy in the TPL/Subrogation Dept 702-304-5500 option 8 x 5293#. Mahalo.

Mahalo.

Sincerely,

Harris Nakamoto

Harris Nakamoto
Vice President / General Manager

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LIFE & HEALTH INSURANCE COMPANY

Dear Summerlin Life & Health 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 a 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 and C, 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 soon as possible.

If you need assistance or have any questions regarding how to complete these forms, please contact our Customer Service Department at 951-4645. Or Cyndy in the TPL/Subrogation Dept 702-304-5500 option 8 x 5293#. Mahalo.

**Please do not return pages 1 & 2 of the TPL Questionnaire, these are for your information only.

Mahalo.

Sincerely,

Nancy Gruenhagen

Nancy Gruenhagen

Sr. Manager Recoveries Department

«MEMBER_NAME»

«MEM_ID»

«FROM_DATE_OF__SERVICE» «DX_CODE»

«PLAN_ID»

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

- *1. Please give the date of service/injury/treatment _____
- * 2. Please give type of treatment or injury _____
- * 3.** Please explain HOW injury happened (requiring medical treatment), _____

- *4. Was your medical treatment the result of a Third Party? Please circle: YES or NO
If Yes, please state: At fault parties Name _____
5. Where did the injury or incident occur? _____
6. Was this at a place of: Please circle: Business or Residence
Location of Business or Residence. _____
7. Name of Homeowner or Property Insurance (*if Liable*) _____
Policy & Claim # _____ Phone# _____
8. Did your injury occur at work? Please circle: YES or NO
If Yes, please state: Company Name/Place of Employment _____
9. The name of the Worker Compensation Insurance Company: _____
10. The claim Number: _____
11. Name and phone number of contact person: _____
- 12.. 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# _____

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»

«MEM_ID»

«FROM_DATE_OF__SERVICE» «DX_CODE»

«PLAN_ID»

SECTION B (FOR MOTOR VEHICLE ACCIDENTS)

1. * Please give the date of the accident: _____
* Please give type of treatment or injury _____
*2. * Briefly explain **HOW** accident 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. * What is the Name & Phone# of *your* Auto Insurance company? _____

Has a claim been filed? _____ *If Yes*, Claim # _____

What is the insurance policy number? _____

*Is there Personal Injury Protection Coverage? (MEDPAY) Yes _____ Amt\$ _____ No _____ Unknown? _____

Please provide PIP Detail Log of payments made once PIP is exhausted & required before claims can be reprocessed!

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

7. What is the Name & Phone# of the insurance company? _____

Has a claim been filed? _____ *If Yes*, Claim # _____

What is the Insurance Policy number? _____

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 & Phone# _____

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» «MEM_ID» «FROM_DATE_OF_SERVICE» «DX_CODE» «PLAN_ID»

