THIRD PARTY LIABILITY

InterCommunity Health Network CCO

Samaritan Health Plans needs your help. We have received information that you were possibly in an accident that could be the responsibility of someone else or another insurance carrier, such as auto insurance, workers compensation, homeowners, etc.

If you have questions, please contact our Customer Service Department at 541-768-4550 or toll-free at 800-832-4580 (TTY: 800-735-2900), daily from 8 a.m. to 8 p.m. Fax # 541-768-9356

To ensure prompt processing of your claim(s), please provide the following information and mail to Samaritan Health Plans, ATTN: TPLC, PO Box 1310, Corvallis, OR 97339. Or fax to 541-768-9356.

MEMBER INFORMATION

Member name: ______________________ Date of injury: ______________________

Member ID: ______________________

This injury was a result of:
(check one of the following)

- ❑ Motor vehicle accident
- ❑ Work-related incident
- ❑ A fall at home
- ❑ A fall elsewhere (please explain)
- ❑ A crime
- ❑ Other (please explain)

Briefly describe what happened or why treatment was sought:

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PLEASE LIST ALL THE INJURIES OR BODY AREAS INVOLVED so we can set up accurate claims processing:

INSTRUCTIONS

1. If this is a result of a **motor vehicle accident**, please also fill out **Section A** on page 2.
2. If this is a result of a **work-related incident**, please also fill out **Section B** on page 2.
3. If this is related to **homeowners**, please also fill out **Section C** on page 2.
4. If you have an **attorney** representing you, please also fill out **Section D** on page 3.
5. If there was **no accident**, please fill in the section above, sign and return the first and last page

SECTION A: MOTOR VEHICLE ACCIDENT	
Your auto insurance:	Agent:
Policy number:	Phone:
Claim number:	
Adjustor:	Adjustor phone:
Personal injury protection (PIP) coverage amount:	
Other driver's name:	
Other driver's insurance company:	
Other insurance company adjustor:	
Phone:	Claim number:
Provide basic information about the accident. (i.e. single car, multi-car, were you a driver or passenger, who was at fault, etc…)	

SECTION B: WORK-RELATED INCIDENT	
Employer name:	Phone:
Employer's workers comp insurance carrier:	
Adjustor:	
Phone:	Claim number:
Provide basic information about the injury/illness.	

SECTION C: HOMEOWNERS POLICY	
Homeowner's insurance company:	
Agent:	Phone:
Policy:	Claim number:
Insured's name:	
Insured's address:	
Adjustor:	Adjustor phone:
List the medical coverage amount:	
Provide basic information about the injury.	

SECTION D: ATTORNEY REPRESENTATION	
Attorney name:	Phone:
Address:	

NOTICE OF SUBROGATION PROVISION:

Samaritan Health Plans has the right to be reimbursed for benefits paid under your insurance policy for health care services incurred as a result of an injury or condition for which another party is liable, or another insurance company is liable for covering. The Plan can recover from you and/or the responsible party. This is called subrogation or right of reimbursement. Samaritan Health Plans may be reimbursed directly from a settlement derived from any other insurance policy or legal action, including, but not limited to workers' compensation coverage, an automobile liability settlement, Personal Injury Protection, uninsured or underinsured motorist coverage, homeowners or other similar type insurance or contract.

If your injury is due to an automobile accident, whether you are at fault or not, and you or the person at fault has coverage under an automobile policy for medical expenses, then the automobile policy will be considered the only coverage until their medical coverage has either exhausted or expired. Workers compensation coverage is your only coverage for work related injuries.

Samaritan Health Plans is not obligated to pay for services necessary due to an injury or condition for which a third party is liable unless or until you, or someone legally qualified and authorized to act for you, promises in writing to carry out the terms of your contract.

Print name: ____

Signature: ____ Date: ______________________________

Address: ____