



www.rmhp.org

To help keep health care premiums down, we research certain claims to find out if another insurance carrier or party may be responsible for payment. This research also helps ensure you get the coverage your plan provides as quickly as possible.

Please answer the questions below and have the provider who treated you send the information to Rocky Mountain Health Plans. Without this information, payment on your claims may be delayed, or you may be responsible for the cost of the care.

Member Information
Member Name _____
RMHP Member ID Number: _____
If you are not the member, what is your relationship to this member? Your Home Phone _____ Your Work Phone _____
What is the medical condition you are being seen for? i.e. neck, back, etc. _____
What was the cause of the medical condition? _____

Injury Information
Date of accident / Injury / condition or illness: _____
Accident / injury / condition or illness occurred at: <input type="checkbox"/> A business <input type="checkbox"/> Your employer <input type="checkbox"/> Residence <input type="checkbox"/> Auto related <input type="checkbox"/> Sports or recreational activity <input type="checkbox"/> Other
Address where injury / accident / illness occurred Name _____ Address _____ City _____ State _____ Zip _____ Is this your home? No <input type="checkbox"/> Yes <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/>

Please complete the section that relates to your incident.

Recreational (i.e. Snowboarding, Four wheeling, sports or similar activities)
If motorized vehicle and you are not the owner, please provide name and address of owner. Name _____ Address _____ City _____ State _____ Zip _____ Telephone Number: _____ Is there medical insurance coverage on this vehicle? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, provide carrier and policy number Policy Number: _____ Was there another party involved in this incident? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, provide name and address: Name _____ Address _____ City _____ State _____ Zip _____

Workers Compensation Information

If your accident / injury / condition or illness is work related, please fill in the appropriate information:

Employer Name _____
Workers Comp Carrier _____
Address _____
City _____ State _____ Zip _____
Carrier's Telephone Number _____
Contact Name _____
If self employed, do you carry worker's compensation Insurance? No Yes
Has a worker's compensation claim been filed? No Yes
If yes, Claim # _____

Auto Information

Did your accident / Illness occur while or due to:
Loading / unloading / entering or exiting a vehicle? No Yes
Doing maintenance on a vehicle? No Yes
If you are not the owner , please provide name, address and phone number of owner.
Name _____
Address _____
City _____ State _____ Zip _____
Telephone Number _____
If you are the owner please provide Auto Carrier Name:
Address _____
City _____ State _____ Zip _____
Is it due to an automobile accident? No Yes
Have you retained an attorney? If so:
Attorney's Name _____
Phone Number _____
Address _____
City _____ State _____ Zip _____
If your accident / injury is related to any of the above, please provide RMHP with a copy of your auto policy declaration page that was in effect on the date of the incident. If a copy of the accident report is available, please attach both to this letter and return to RMHP.
Your Home Phone _____
Daytime Phone _____
Your Signature _____ Date _____

This information is being requested in accordance with your Member Benefit Contract. We appreciate the opportunity to serve you.

If you have questions, please call Customer Service. Monday – Friday. 8:00 a.m. to 5:00 p.m.

- RMHP members call 970-243-7050 or 800-346-4643.
- If you are hearing impaired and use TTY equipment, call 711.
- Para asistencia en español llame al 800-346-4643.

Sincerely,

Financial Recovery
Rocky Mountain Health Plans