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:

☐ A business ☐ Your employer ☐ Residence ☐ Auto related

☐ Sports or recreational activity ☐ Other

Address where injury / accident / illness occurred

Name ____

Address ____

City_______________________________________ State ____________ Zip ___________________

Is this your home? No ☐ Yes ☐ Own ☐ Rent ☐

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 ☐ Yes ☐

If yes, provide carrier and policy number

Policy Number: ____

Was there another party involved in this incident? No ☐ Yes ☐

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