

Correspondence Cover Sheet

Beneficiary's Name: CLARKE, DEBORAH L
Medicare ID: 8R81A03PJ34
Date of Incident: April 04, 2018
Case Identification Number: 20190 98090 01648
Insurer Policy Number: S 301898669690001 P RWD3001221
Insurer Claim Number: 301898669690001

This cover sheet is for your use when mailing or faxing in correspondence to the Benefits Coordination & Recovery Center (BCRC). Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the BCRC to facilitate routing. Check all that apply:

- Payment Enclosed
- Settlement information
- Retainer agreement or other authorization documentation
- Other _____

Note: A Conditional Payment Letter is sent automatically within 65 days of this letter, or as soon as the information is available. **Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.**

In order to accurately associate claims to your case, please include a description of the injury. (i.e.: Knee, Physical Therapy, Slip and Fall, Lumbar Injury...)

Submit correspondence to the BCRC address listed below:

Liability Insurance or No Fault Insurance Workers' Compensation:

NGHP
PO BOX 138832
OKLAHOMA CITY, OK 73113
405-869-3309