

INGUMR200



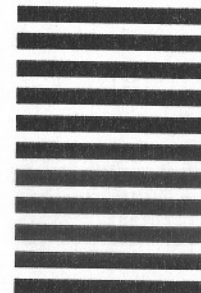
NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 23810 MINNEAPOLIS MN

POSTAGE WILL BE PAID BY ADDRESSEE

UMR SUBROGATION SERVICES
WI105-N1000
PO BOX 19099
GREEN BAY WI 54307-9827



UMR
WI105-N1000
PO Box 19099
Green Bay, WI 54307-9827



1-866-257-3378

2196473PAE0098601

ROBERT PLOCK
6827 LATTA PKWY
DALLAS TX 75227

SECOND REQUEST

August 07, 2013

Patient Name: ROBERT PLOCK
Treatment on: 03/04/2013
Case #: 22376351

Dear ROBERT PLOCK,

UMR has paid medical benefits for the above listed patient under your group health plan. We need to obtain additional information from you concerning this claim.

Please complete this questionnaire to assist us in reviewing this claim. This information will help determine if UMR can be reimbursed by some other insurer, organization or responsible person associated with or involved in an accident.

If the medical condition of the patient listed above was not caused by an accident, please do not disregard this letter. You may respond, either by completion of the questionnaire or by contacting a customer service representative at the number listed below.

This will eliminate the need for future contact regarding this matter.

We have enclosed a postage paid envelope for your convenience. You may also provide this information to us via our secure web site or by telephone at:

Web / Internet
www.recoveryfacts.com
24 hours per day

Toll Free (telephone)
Voice - 866 257 3378
TTY - 866 876 2784
7:00am to 7:00pm CST, Mon-Fri

Thank you for your cooperation,

UMR

Por favor mire al otro lado para las preguntas en español.

UMR
WI105-N1000
PO Box 19099
Green Bay WI 54307-9827



1-866-257-3378

Case # 22376351

Date of Injury _____
(Please complete)

Health Plan _____

Patient's Name ROBERT PLOCK

1. Was your treatment due to: (please check one below)

<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Medical Malpractice
<input type="checkbox"/> Home Injury	<input type="checkbox"/> Liability (like a Slip or Fall)
<input type="checkbox"/> Work Accident or Injury	<input type="checkbox"/> Other/Not an Accident (Explain below)

2. Please describe **how** and **where** this injury happened.

What state did this happen in? _____

3. Was anyone other than yourself responsible for your injury? _____ Yes _____ No
If "yes" and you are making a claim against them, please list their Insurance Company name, address, phone number, fax number, email address, policy number, and claim number.

4. Was a Police Report made? _____ Yes _____ No
Name and City of Department (if "yes").

5. If this was from an auto accident, please list the name, address, phone number, fax number, email address, policy number, and claim number of *your own* car insurance.

6. Did you hire an attorney to represent you? _____ Yes _____ No
If "yes", please list their name, address, telephone number, email address, and fax number.

7. At what telephone number or email address may we contact you?

22376351

Por favor mire al otro lado para las preguntas en español.