Subrogation & Reimbursement

Because another party may be legally liable for your medical expenses, your plan of benefits requires the signing of a Subrogation and Reimbursement Agreement before the claim can be processed.

The attached form, when signed will enable the third party or other applicable insurance company or entity to reimburse your plan for the medical payments made to you. If there is no reimbursement from the third party or other applicable insurance company or entity, nothing will be due The Plan.

Your cooperation in signing and returning the agreement and this letter with the information requested below as soon as possible will expedite the handling of the claims(s).

If you have not already completed an Accident Questionnaire, please do so and return it to Patient Advocates, LLC with this form.

Please do not hesitate to contact us with any questions concerning this information.
Thank you.

Sincerely,

Customer Service

Patient Advocates, LLC
P.O. Box 1959
Gray, Maine 04039
1-800-290-8559
Fax (207) 657-7744

Subrogation & Reimbursement Agreement

Employee Name:________________________________
ID#:______________________________

Patient Name:___________________________________
Employer:_________________________

Date of Injury:_________________________________
Group#:___________________________

A. SUBROGATION AND REIMBURSEMENT AGREEMENT:

I,______________________________, have read and understand the 'Right to Subrogation and Reimbursement' section in my Employee Benefit Plan Document. I agree that by accepting benefits under my employee benefit plan for an accidental injury or illness, I will reimburse the contract administrator in an amount equal to the value of those benefits paid in the event of recovery from a third party as a result of such injury or illness. Recovery includes any amount received, whether by judgment, decree, settlement, or otherwise.

B. WORKER'S COMPENSATION AGREEMENT:

I,___________________________, have read and understand 'The Right to Provisional Payment of Claims for Work-Related Injury or Sickness' contained in my Employee Benefit Plan Document and agree that by accepting benefits under my employee benefit plan for an injury or illness arising out of and in the course of employment, I will reimburse the contract administrator in an amount equal to the value of those benefits paid in the event of a recovery from the worker's compensation carrier or employer as a result of such injury or illness. Recovery includes any amount received whether by judgment, decree, settlement, or otherwise.

I also authorize any responsible third party or their insurer, worker's compensation carrier, or the representing attorney, to reimburse Patient Advocates, LLC in its capacity as contract administrator, directly for benefits paid as an alternative to reimbursing me, but only to the extent of any payments made on behalf of myself and/or dependents under my employee benefit plan.

_________________________________ _________________________
Signature of Covered Employee Date

_________________________________ _________________________
Signature of Patient (If Different) Date

_________________________________ _________________________
Witness Date

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