



# Subrogation Referral Form NEW MEXICO HEALTH CONNECTIONS

Please use this form to fax referral information to FIRST RECOVERY GROUP at 248-443-4804. If you have any questions, you may contact Josh Holmberg at 877-449-4803 or mail information to: First Recovery Group Attn: Josh Holmberg 26899 Northwestern Hwy. Suite 250, Southfield, MI 48033, or email: Referrals@FirstRecoveryGroup.com

Your Name: \_\_\_\_\_

Your Phone #: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date of Loss: \_\_\_\_\_

Member's ID: \_\_\_\_\_

Member Name: \_\_\_\_\_

Member DOB: \_\_\_\_\_

Member SSN: \_\_\_\_\_

Notes:

Member Address: \_\_\_\_\_

Enrollment Plan: \_\_\_\_\_

Enrollment State: \_\_\_\_\_ Plan Type: \_\_\_\_\_

(Medicaid/Medicare/Commercial/etc.)

Accident Type:

Motor Vehicle Accident     Motorcycle Accident     Worker's Compensation

Injury on someone else's property     Other: \_\_\_\_\_

### Attorney Information

Attorney Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

### Other Insurance Information

Insurance Name: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_