



Office of the General Counsel
 Subrogation Department
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 (517) 325-4658
 FAX No. (877) 257-2012
 E-mail: SubrogationUnit@bcbsm.com

BCBSM SUBROGATION QUESTIONNAIRE

FAX COMPLETED FORM TO 877-257-2012 or MAIL TO ADDRESS ABOVE

| | | | |
|---|-------------------------------------|-----------------------------|---------------|
| Date | Patient Name | Date of Birth | |
| Contract # (9 digit number on BCBSM card) | | Spouse (if on BCBSM policy) | |
| BCBSM policy holder's name (if different from the patient's name) | | | Date of Birth |
| Your phone number | | | |
| Type of case (select one) | | | |
| <input type="checkbox"/> Personal Injury <input type="checkbox"/> Product liability <input type="checkbox"/> Medical malpractice <input type="checkbox"/> Workers' compensation | | | |
| <input type="checkbox"/> Motor vehicle accident In what state did it occur? _____ In what state does the liable party live? _____ | | | |
| <input type="checkbox"/> Motorcycle accident Was a vehicle involved? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| <input type="checkbox"/> Other _____ | | | |
| Court or workers comp bureau, if known | | | |
| Date of injury | Type of injury/area of body injured | | |
| NOTES: | | | |

| | | | |
|-------------------------------------|------|---------------------|----------|
| Attorney name (if you've hired one) | | | |
| Attorney law firm name | | | |
| Attorney street address | City | State | Zip code |
| Attorney phone number | | Attorney fax number | |

| | | | |
|--|------|-------------------------------|----------|
| Insurance company name | | | |
| Insurance adjuster name | | Insurance claim number | |
| Insurance company street address | City | State | Zip code |
| Insurance adjuster phone number | | Insurance adjuster fax number | |
| Date and type of next scheduled hearing date | | | |

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Blue Cross Blue Shield is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association