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BCBSM SUBROGATION UNIT QUESTIONNAIRE

FAX COMPLETED FORM TO 877-257-2012

Date	Client's Name				Date of Birth	
Contract # (9 digit number on BC	RSM card)		Shouse (if on BCRSM r	ooliev)		
Contract # (9 digit number on BCBSM card) Spouse (if on BCBSM policy)						
BCBSM policy holder's name (if different from the client's name)			Date of Bir		Date of Birt	h
Client's phone number						
Type of case (select one)						
Personal Injury Product liability Medical malpractice Workers' compensation (Please fax the application if in Michigan)						
Motor vehicle accident In what state did it occur? In what state does the liable party live?						
Motorcycle accident Was a vehicle involved? Yes No						
Other						
Venue/Jurisdiction of cause of action						
Date of injury T	Type of injury/area of body injured					
NOTES:						
Attorney name						
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		<u> </u>	Insurance adjuster fax number			
Date and type of next scheduled hearing date						

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