



Third Party Recovery Services
 P.O Box 34602
 Washington, D.C. 20043
 (202) 683-9140 Fax: (202) 833-2027

MAIL HANDLERS BENEFIT PLAN REIMBURSEMENT QUESTIONNAIRE
FAX COMPLETED FORM TO 202-833-2027 or MAIL TO ABOVE ADDRESS WITHIN FIVE (5) DAYS FROM RECEIPT
OR COMPLETE ONLINE: http://ermerlaw.com/Quest_MHBP/index.html Username: MHBP, Password: haxeV5mA

Date:	Patient Name:	Date of Birth:	
MHBP ID No.:		Patient Relationship to Enrollee:	
Your Name (if not the patient):		Your relationship to Enrollee:	
Your Phone #: () -	Your E-Mail Address:	Contact me by:	
Your Fax # (if available): () -		<input type="checkbox"/> Telephone [Best time AM or PM]	<input type="checkbox"/> E-Mail
Cause of Illness or Injury (select one):			
<input type="checkbox"/> Slip & Fall <input type="checkbox"/> Product Liability <input type="checkbox"/> Medical Malpractice <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Other (for example, assault, dog bite, food poisoning): _____ <input type="checkbox"/> No Known Cause			
Location where injury or illness occurred			
<input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other – Describe _____			
Date of Injury or Illness:	Describe the Cause of the Injury or Illness: ** Please include copies of any accident reports**		

Name of Attorney (if you've hired one):			
Name of Law Firm:			
Street Address		City	State Zip Code
Attorney phone number: () -	Attorney fax number: () -	Attorney E-Mail Address:	

Name of Auto/Other Liability/Workers' Compensation Insurer:		Policyholder:	
Insurance Adjustor Name:		Insurance Claim Number:	
Insurance Company's Street Address:		City	State Zip Code
Adjustor phone number: () -	Adjustor fax number: () -	Type of Insurance: <input type="checkbox"/> Bodily Injury/Liability <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Personal Injury Protection/Med Pay/ No-Fault <input type="checkbox"/> Uninsured/Underinsured Motorist	

I agree that the above information is correct, and that I will not settle a claim before contacting TPRS.

Signature _____ Date: _____