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

RURAL CARRIER 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_RCBP/index.html Username: RCBP, Password: haxeV5mA

Date:	Patient Name:	Date of Birth:

RCBP 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: ☐ Telephone [Best time AM or PM] ☐ E-Mail
Your Fax # (if available): ( ) -		

Cause of Illness or Injury (select one):

☐ Slip & Fall ☐ Product Liability ☐ Medical Malpractice ☐ Motor Vehicle Accident ☐ Workers' Compensation

☐ Other (for example, assault, dog bite, food poisoning): ______________________ ☐ No Known Cause

Location where injury or illness occurred

☐ Work ☐ Home ☐ 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: ☐ Bodily Injury/Liability ☐ Workers' Comp ☐ Personal Injury Protection/Med Pay/ No-Fault ☐ Uninsured/Underinsured Motorist

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

Signature_______________________________________ Date: ______________