SWSCHP
P.O Box 5035
White Plains, NY 10602-5035
Phone: (888) 779-7247 / (888) P-SWSCHP

Fax: (914) 367-4108

Date:

Participant: _____ **Participant ID #:**

Patient: _____ **Patient account#:**

Claim#:

Dear _____**:**

We wish to acknowledge receipt of a claim for the above named patient. In order to determine benefits, we need your response to the questions below. If you have already responded to this letter on a related claim, you may disregard this letter.

1. **Is the condition the result of an accident or illness? ( ) Accident ( ) Illness**

2. **If accident, describe where, when and how the accident occurred:**

   Where:
   When:
   How:

   Is the accident automobile related? ( ) Yes ( ) No

3. **If illness, provide a description of the condition and indicate when it occurred.**

4. **If the patient is employed, indicate if the accident or condition is related to or caused by the patient's employment. ( )Yes ( )No**

5. **Is another party responsible for the accident or personal injury? ( ) Yes ( ) No**

6. **If yes, has the patient made a personal injury claim, received, or expect to receive, a personal injury settlement? ( ) Yes ( ) No**

7. **Provide the name and contact information for the responsible party and/or your attorney or insurance company.** _____

Please return the completed letter to the address above or the fax number so that we can complete the processing of your claim. Please note that the requested information must be received within 45 days of the date of this letter. If not received, no further action can be taken on this claim.

I hereby certify that the information provided above is true and accurate.

Participant signature:_____ **Date:**

Thank you for your cooperation.