



## Correspondence Cover Sheet

Beneficiary Name:  
Medicare ID:  
Date of Incident:  
Case Identification Number:  
Insurer Claim Number:

This cover sheet is for your use when mailing or faxing in correspondence to the Benefits Coordination & Recovery Center (BCRC). Please retain a COPY of this cover sheet for any future correspondence. The information above will ensure accuracy when handling your case documentation.

Please indicate the type of correspondence you are submitting to the BCRC to facilitate routing.

Check all that apply:

- Payment enclosed
- Settlement information
- Retainer agreement or other authorization documentation

Other \_\_\_\_\_

**Note:** A Conditional Payment Letter is sent automatically within 65 days of this letter, or as soon as the information is available. **Separate requests for initial Conditional Payment Amounts will not make Conditional Payment information available sooner.**

In order to accurately associate claims to your case, please include a description of the injury. (i.e. Knee, Physical Therapy, Slip and Fall, Lumbar Injury....)

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**Submit Correspondence to the BCRC address listed below:**

Liability Insurance or No-Fault Insurance Workers' Compensation  
NGHP  
PO Box 138832  
Oklahoma City, OK 73113