



Office of the General Counsel  
 Subrogation Department  
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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 BCBSM card)		Spouse (if on BCBSM policy)
BCBSM policy holder's name (if different from the client's name)		Date of Birth
Client's phone number		
Type of case (select one)		
<input type="checkbox"/> Personal Injury <input type="checkbox"/> Product liability <input type="checkbox"/> Medical malpractice <input type="checkbox"/> Workers' compensation (Please fax the application if in Michigan)		
<input type="checkbox"/> Motor vehicle accident            In what state did it occur? _____            In what state does the liable party live? _____		
<input type="checkbox"/> Motorcycle accident            Was a vehicle involved? Yes <input type="checkbox"/> No <input type="checkbox"/>		
<input type="checkbox"/> Other _____		
Venue/Jurisdiction of cause of action		
Date of injury	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		Insurance adjuster fax number	
Date and type of next scheduled hearing date			

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