

[YOUR LETTERHEAD]

Medicare – Coordination of Benefits
P.O. Box 33847
Detroit, MI 48232-5847

Dear Sirs:

This is a first report of a pending liability claim.

1. The following Medicare beneficiary has a pending liability claim:

Beneficiary Name:
Health Insurance Claim Number:
Gender:
Date of Birth:
Address:
Telephone Number:

2. The case information is as follows:

Date of injury/accident, first exposure, ingestion or implant:
Description of alleged injury, illness or harm:
Type of claim: (Liability insurance or no-fault insurance)
Name and address of insurer:

3. Our information as representative is as follows:

Attorney name:
Law firm name:
Our address and telephone number:

Very truly yours,