Puyallup Tribal Health Authority
2209 East 32nd Street I Tacoma, WA 98404
Phone: (253) 593-0232 I www.eptha.com

SUBROGATION AGREEMENT

Puyallup Tribal Health Authority (PTHA) as a payor of last resort provided medical services to you and when applicable paid for medical services on your behalf related to your injuries that occurred on ___/___/____. To the extent that another party may be liable for those injuries, PTHA is entitled to recover those payments made on your behalf from the other party; this is known as "subrogation". PTHA requests your assistance in recovering these payments by signing the below statement.

I understand that if PTHA paid for services or supplies for me, I will subrogate to PTHA all rights of recovery that I may have against any persons and/or organizations that are related to the incident(s) that necessitated the rendering of the services or supplies, to the extent those services or supplies were provided to me. PTHA is entitled to reimbursement for the sums paid for services or supplies for me and any attorney's fees or costs associated with the collection of that reimbursement. I agree to cooperate with PTHA in its efforts to collect reimbursement on behalf of the services and supplies it provided to me. These subrogation rights extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated.

I shall promptly execute and deliver instruments and papers related to these subrogation rights as may be requested by PTHA. Further, I shall promptly notify PTHA of any settlement negotiations prior to entering into a settlement agreement affecting PTHA's subrogation rights.

I hereby authorize PTHA, and anyone acting on behalf of it, to release any information about my injuries and the benefits and medical services I received in connection with those injuries to any persons who may be liable to me or PTHA, and to the insurance company of any such person or to any insurance company that provides coverage for these injuries.

My signature below constitutes evidence of my agreement to cooperate with PTHA and to assign reimbursement rights to PTHA for costs paid on my behalf from a third party who may be liable for my injuries.

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed name of patient or legal representative Relationship to the patient

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For Office Use:

Patient Name:	
ID No:	
Patient Address:	
Injury Date:	
Date(s) of Service:	
Provider(s) of Service	

INCIDENT REPORT QUESTIONNAIRE

Based on our information, the treatment received on the date(s) listed below may have been the result of an injury or accident. PTHA needs additional information in order to determine financial responsibility for the injuries. Please complete this form and return it with thirty (30) days of receipt in the enclosed self-addressed stamped envelope.

Please Answer the Questions Below

Please attach additional information if applicable

Background Information

1. Date of Incident or Event _____ Time: _____ AM/PM
2. Date of Treatment: _____ Time: _____ AM/PM

   If there were multiple treatment dates, please indicate below:

   Date of Treatment: _____ Time: _____ AM/PM

   Date of Treatment: _____ Time: _____ AM/PM

   Date of Treatment: _____ Time: _____ AM/PM
3. Briefly describe the circumstances that caused you to seek treatment:

4. Please describe your injuries or medical condition in detail:

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Please answer all applicable questions.

Motor Vehicle Accident Information - if applicable, please attach a copy of your insurance policy page that states the monetary amounts of the coverage related to this incident.

1. Was the injury a result of a motor vehicle accident? Yes/No (please circle)
2. The patient was a:

   ☐Driver ☐Passenger ☐Pedestrian ☐Other: _____
3. The vehicle was a:

   ☐Car ☐Motorcycle ☐Truck ☐Other: _____
4. Name of party responsible for the injury: _____
5. Responsible Party's Driver's License Number: _____
6. Responsible Party's Insurance Company: _____
7. Insurance Company's Address: _____
8. Adjuster's Name: _____Phone: _____
9. Claim Number: _____
10. Do you have vehicle insurance? Yes/No (please circle)
11. Is there medical coverage under your vehicle insurance? Yes/No (please circle)
12. Name of your Insurance Company: _____
13. Your insurance company's address: _____
14. Adjuster's Name: _____ Phone: _____
15. Claim Number: _____
16. Name(s) of other Family Members Injured: _____

    _____

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Other Cause of Injury

If your claim was denied, please attach a copy of the denial.

1. Did the injury occur on the job? Yes/No (please circle)
2. If Yes, enter the Worker's Compensation Claim Number: _____
3. Are you a police officer or firefighter? Yes/No (please circle)
4. Did the injury occur on someone else's property? Yes/No (please circle)
5. Did the incident occur on public or tribal property? Yes/No (please circle)
6. Address of location: _____
7. Name of responsible party: _____
8. Responsible party's insurance company: _____
9. Insurance company's address: _____
10. Adjuster's name: _____ Phone: _____
11. Claim Number: _____

Legal Representation

1. Have you retained an Attorney? Yes/No (please circle)
2. Attorney's Name: _____ Phone: _____
3. Address: _____
4. Law Firm: _____
5. Have you instituted legal action: _____
6. If yes, please provide information regarding any settlement negotiations, trial dates, and the court in which the action was filed:

_____

_____

_____