TRIBAL
HEALTH PARTNERS T.P.A., L.L.C.

DATE: _____

EMPLOYEE: _____

SS#_____

PATIENT:_____ DATE OF SERVICE: _____

We have recently declined a claim on you/your family member for additional information. Please complete this questionnaire and return to us.

1. Date of Accident/Injury: _____
2. Description of the Accident/Injury: _____
   _____
   _____
3. Location of the Accident/Injury: _____
   _____
4. Was this incident work related? O Yes or O No

Upon receipt of this completed questionnaire we will reconsider your claim for payment. Our phone number is 888-419-6139.

DOCTOR VISIT ON _____

In addition, would you please affix your signature to the bottom of this letter and date it, indicating that the information contained is accurate to the best of your knowledge. Your cooperation is, of course, appreciated!

BY SIGNATURE AFFIXED AND DATED HEREWITH, I STATE THAT THE FACTS STATED ARE TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____
Name

_____
Date Signed

Sincerely,

TRIBAL HEALTH PARTNERS

PO Box 71490, Phoenix, AZ 85050
Phone: 1-888-419-6139 Fax: 623-889-7299