BCRC Case Closure Detail Document

Beneficiary's Name: _____

Medicare Number: _____

Date of Incident/Injury: _____

Case Identification Number: _____

Amount of policy limit: _____

Were policy limits exhausted? ☐ Yes ☐ No

Date policy was exhausted: _____

Date beneficiary stopped treatment * (if benefits are not exhausted): _____

**If the benefits are not exhausted and there is no possibility of associated future treatment, a signed physician's statement that he/she will require no treatment associated with the claim/claimed injuries must be provided.*

Statute of Limitations Date: _____

Name of person who is providing this information: _____

Insurer/Workers' Compensation Information:

Claim Number: _____

Address: _____

City, State, ZIP Code: _____

Phone Number: _____

Please provide a payment ledger/payment log detailing what bills were paid for the date of the incident/injury above for further consideration. A payment ledger/payment log should include:

- The date of service
- The billed amount
- Provider/facility name
- Who was paid
- Date payment was made
- Amount paid

This completed document, with the payment ledger/payment log attached, should be sent to the address below. If you have any questions concerning this matter, please call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TYY/TDD: 1-855-797-2627 for hearing and speech impaired) or you may contact us in writing at the address below. If you contact us in writing, please be sure to include the beneficiary's name and Medicare number as well as the case identification number for the date of incident/injury in question.

NGHP
P.O. Box 138832
Oklahoma City, OK 73113