



## **Final Settlement Detail Document**

Beneficiary Name:  
Medicare Number:  
Date of Incident:  
Case Identification Number:

Please supply the information outlined below to help Medicare to properly calculate the amount it is due. This information will also be used to update your records.

**Total Amount of the Settlement:**

\_\_\_\_\_

**Total Amount of Med-Pay or PIP:**

\_\_\_\_\_

*\*\*only if paid directly to the beneficiary  
or the beneficiary's representative*

**Attorney Fee Amount Paid by the Beneficiary:**

\_\_\_\_\_

**Additional Procurement Expenses Paid by the Beneficiary:**

\_\_\_\_\_

(Please submit an itemized listing of these expenses)

**Date the Case Was Settled:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Description of Injuries:**

\_\_\_\_\_

**Name of person who is providing this information:**

\_\_\_\_\_

**Relationship with the Beneficiary:**

\_\_\_\_\_

This information should be submitted to:

NGHP  
PO Box 138832  
Oklahoma City, OK 73113

If you have any questions concerning this matter, please contact the Benefit Coordination & Recovery Center (BCRC) by phone at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired), in writing at the address above, or by fax to 405-869-3309. When sending correspondence, please include the Beneficiary Name along with the Medicare and Case Identification Numbers (shown above).