Sanford Health Plan
POBox 8000
Marshfield, WI 54449-8000

Forwarding Service Requested
Important Plan Information

KAREN JOHNSON
100 MAIN ST
ANYTOWN, SD 55555

08/04/2026

Dear KAREN JOHNSON:

Member: KAREN JOHNSON
Date of service/diagnosis: 03/03/2026/S22.070A WEDGE COMPRS FX T9-T10 VERT INIT ENC CLOS FX
Account#: SUB191282

Thank you for being a member of Sanford Health Plan. It is our mission to help you reach your best health by ensuring access to affordable and high quality health care.

We have received claims for your injury or illness that occurred on or about the above date and have a few questions related to those claims. Answering these questions will help us to evaluate and possibly pursue subrogation and/or reimbursement. Subrogation is the process to recover any money paid that should be the responsibility of a third party. Further information about this recovery process is available in your Sanford Health Plan Certificate of Coverage which can be found in your MyChart member portal.

Please complete the form, sign, and date the reverse side of this letter and return it to our office in the enclosed envelope. This form may be faxed to (715)-221-9420, emailed to **shp.subrogation-mfld@Sanfordhealth.org.**

This information must be received in our office within 30 days from the original date of this letter. Failure to return this letter on time may result in the delay or denial of this claim and any other related charges.

If you have any additional questions, please call us at (888) 213-4883 (TTY:711) . Our hours are 8 a.m. to 5 p.m. Monday through Friday CT.

Sincerely,

Subrogation Department

Enc: Nondiscrimination notice
HP-8100 202606

Date of service: 03/03/2026
Diagnosis: S22.070A WEDGE COMPRS FX T9-T10 VERT INIT ENC CLOS FX

Section A -- Please complete and return.
1. Please describe what happened _____
_____
2. On what date did the injury or illness happen or begin?_____Are you still treating?_____
3. What injuries did you sustain?_____
4. Was the injury or illness a result of:
__ Accident - involving motorized transportation. Including but not limited to: Car, truck, boat, camper, ATV, snowmobile, moped, dirt bike. ***Complete section B & C below**
__ Something that happened on someone else's property. ***Complete section C below**
__ Accident at home.
__ Something else. ***Complete section C below**

Section B -- Accident - motorized transportation.
Name of the driver _____ What type of motorized vehicle was involved?_____
What safety equipment were you wearing? (included but not limited to: seatbelts, helmet, goggles)_____
Provide names of others in or on the vehicle: _____
Where can we get a copy of the police report? _____ Did anyone receive a traffic ticket? ____

Section C --Complete Liability Insurance Information.
Please name who caused the injury or illness.
Name_____
Address_____ Phone number_____
City_____ State _____ ZIP Code_____
Name other liability insurance involved.
Name of insurance_____
Address_____ Phone number_____
City_____ State _____ ZIP Code_____
Claim Number_____ Adjuster _____
Name of Your Liability Insurance.
Name of insurance_____
Address_____ Phone number_____
City_____ State _____ ZIP Code_____
Claim Number_____ Adjuster _____

Section D -- Complete only if work related.
Are you self employed? YES or NO Was the injury or illness related to your job? YES or NO
Was the injury or illness reported to your employer? YES or NO
Please name the employer.
Name_____
Address_____ Phone number_____
City_____ State _____ ZIP Code_____
Please name the employer's workers' compensation insurance.
Name of insurance_____
Address_____ Phone number_____
City_____ State _____ ZIP Code_____
Claim Number_____ Adjuster _____

Section E -- Do you have an attorney for this case or is a District Attorney involved? YES or NO
Name_____
Address_____ Phone number_____
City_____ State _____ ZIP Code_____

SIGNATURE_____**DATE**_____
HP-8100 202606