



## NO-FAULT CASE CLOSURE DETAIL DOCUMENT

**Beneficiary Name:**

**Medicare ID:**

**Date of Incident:**

**Amount of Policy Limit:** \_\_\_\_\_

**Were Policy Limits Exhausted?** (Please Circle One) Yes No

**\* Date Beneficiary Stopped Treatment** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

*\*\* If the benefits are not exhausted and there is no possibility of associated future treatment, a signed statement from the beneficiary's treating physician that he/she will require no treatment associated with the claim/claimed injuries may be provided (but is not required) to assist in processing the case.*

**Date Case Closed:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Exhaust Information Provided By:** \_\_\_\_\_

**Claim Number:** \_\_\_\_\_

**Insurer Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Insurer Phone:** \_\_\_\_\_

This completed form should be sent to the address below.

If you have any questions concerning this matter, please contact the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY/TDD: 1-855-797-2627 for the hearing and speech impaired).

NGHP  
PO Box 138832  
Oklahoma City, OK 73113