BWC Subrogation Referral Form

Claimant _____

Claim No._____ Date of Injury_____

Claimant's PI Attorney and Address

_____

_____

_____

Telephone No._____

Third Party Name and Address

_____

_____

_____

Telephone No._____

Third Party's Insurance Company

Address, Claim No. and Claims Rep

_____

_____

_____

Third Party's Attorney (If known)

Name and Address

_____

_____

_____

Description of Accident

_____

_____

_____

_____

Refer to:

Subrogation Department
P.O. Box 15487
Columbus, OH 43215
Phone: (614) 466-6600
Fax: (614) 621-2549

Referred By:_____
Telephone:_____
Affiliation:_____
Date:_____

Attached:

MVA Report__

Other__ Specify_____