



## CRC 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 Commercial Repayment Center (CRC) 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.

Commercial Repayment Center - NGHP  
P.O. Box 1610  
Lathrop, CA 95330