Date: [Insert Date]

TO: [Insurance Company Name/Registered Agent]
ATTN: Claims Department / Subrogation Unit
Address: [Insert Address]
City, State, Zip: [Insert City, State, Zip]

RE: NOTICE OF SUBROGATION DEMAND
Claimant/Insured: [Insert Name]
Claim Number: [Insert Claim Number]
Policy Number: [Insert Policy Number]
Date of Loss/Injury: [Insert Date]
Opposing Party/Tortfeasor: [Insert Name of Responsible Party]

To Whom It May Concern,

Please be advised that [Your Name/Insurance Company Name] has provided medical benefits and/or payments for injuries sustained by the above-named Insured resulting from the incident occurring on [Date of Loss].

Pursuant to the terms of the insurance contract and applicable state and federal laws, [Your Name/Insurance Company Name] maintains a right of subrogation and/or reimbursement for all medical expenses paid to date, as well as any future payments related to this incident.

Demand Summary:

- Total Medical Expenses Paid to Date: $[Insert Amount]
- Current Outstanding Liens: $[Insert Amount]

Enclosed please find an itemized statement of benefits paid and medical records supporting this demand. We request that you include our name as a co-payee on any settlement check or, in the alternative, issue a separate check to satisfy this lien directly.

Please acknowledge receipt of this notice within [Number] business days. Failure to protect this interest may result in further legal action to recover these costs.

Sincerely,

[Your Name/Signature]
[Your Title]
[Your Phone Number]
[Your Email Address]

Enclosures: Itemized Statement of Benefits, Medical Records Summary.