



75 East Santa Clara Street, Suite 950  
San Jose, CA 95113  
(408) 937-3600

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Subject: Possible Third Party Liability Claim

Dear \_\_\_\_\_:

In order for **Physicians Medical Group of San Jose** to consider your accident/injury claim that occurred on \_\_\_\_\_, please advise if any other party was liable for your injuries. We ask that the attached forms be completed and returned to our office within two weeks of receipt of this correspondence. Please note that claims will be pended until your response is received.

Thank you in advance for your cooperation in this matter.

Sincerely,

TPL Coordinator

Enclosures: Third Party Lien Information Form  
Third Party Lien Assignment Form