Name:

Chart:

Date:

PREMERA | BLUE CROSS

P.O. Box 327 | MS 227 | Seattle, WA 98111

Incident Quesionnaire

Customer Service: 800-722-1471
TDD: 800-842-5357
Fax: 425-918-5878

Patient name and address:

_____

_____

_____

Today's date _____
Patient name _____
Date of birth _____
Member ID number _____
Group number _____
Provider name _____
Date of service _____

To avoid possible delay in processing your claims, please complete, sign, and return this questionnaire within 45 days of receipt.

Our records show that services this patient received could be related to an accident or injury. Claims cannot be processed until this incident questionnaire is fully completed, signed and returned. **Failure to return the questionnaire will result in denial of the claim.**

Required: Briefly describe the circumstances that caused patient to seek treatment:

Was this claim related to an incident/accident?

☐ **Yes** ▶ Complete all sections that apply to this accident or injury, sign and date form, and return by fax or mail

☐ **No** ▶ Call Customer Service at 800-722-1471 **-or-**
Skip to the bottom of page 2 to sign and date the form, and return by fax or mail

1. General Information

Date of incident _____

Location /address of incident _____ State _____

State all injuries and all parts of body affected: *(If not related to a specific incident, please describe what caused the onset of symptoms.)*

2. Please complete this section for motor vehicle accident

Vehicle involved: ☐ Car ☐ Motorcycle ☐ Watercraft ☐ Other (please sepcify) _____

Vehicle involved: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other (please sepcify) _____

List any other member of patient's family injured in this accident:

Name _____ Injuries _____

Name _____ Injuries _____

Patient's vehicle insurance carrier _____ Policy Number _____

Adjuster _____ Phone _____ Claim Number _____

Does the policy include Personal Injury Protection (PIP) or Medical Payment (MedPay) coverage? ☐ Yes ☐ No

Has the patient received a bodily injury settlement? ☐ Yes ☐ No Date of Settlement _____

If the patient was a passenger:

Driver _____

Driver's vehicle insurance carrier _____ Policy Number _____

Adjuster _____ Phone _____ Claim Number _____

Does the policy include Personal Injury Protection (PIP) or Medical Payment (MedPay) coverage? ☐ Yes ☐ No

Has the patient received a bodily injury settlement? ☐ Yes ☐ No Date of Settlement _____

Name:

Chart:

Date:

If another vehicle was involved:

Other driver _____

Vehicle insurance carrier _____ Policy Number _____

Adjuster _____ Phone _____ Claim Number _____

Has the patient received a bodily injury settlement? ☐ Yes ☐ No Date of Settlement _____

Have you filed or do you intend to file a claim? ☐ Yes ☐ No

If no, please explain _____

3. Please complete this section for on the job injury or illness

Did this condition or injury occur on the job or as the result of employment? ☐ Yes ☐ No

Is patient self-employed, owner, or sole proprietor? ☐ Yes ☐ No

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No Claim number (*required*) _____

What is the status of the Workers' Compensation claim? ☐ In review ☐ Accepted ☐ Denied ☐ Appealing

If a Workers' Compensation claim has been filed and denied, please include a copy of the denial letter.

Workers' Compensation carrier _____

Adjuster _____ Phone _____

4. Please complete this section for other accident or injury

Did this accident or injury occur on patient's own property? ☐ Yes ☐ No *(if no, please complete the following)*

Business or property owner _____

Have you filed an insurance claim with the at-fault party or do you anticipate pursuing a claim? ☐ Yes ☐ No

(Medical malpractice, slip and fall, product liability, product recall, another person's home or business, assault, etc.)

If no claim filed, please explain why _____

Other party's insurance carrier *(if known)* _____ Policy Number _____

Adjuster _____ Phone _____ Claim Number _____

5. Please complete this section for attorney information

Have you retained an attorney regarding this incident? ☐ Yes ☐ No *(if yes, please complete the following)*

Attorney _____ Phone _____

Mailing address _____

Your contract with Premera Blue Cross (The Plan) includes a subrogation provision. "Subrogation" means that if The Plan provides any benefits on your behalf for injuries caused by another party who may be liable for those injuries, The Plan may be entitled to recover those costs from any settlement you receive from the at fault party. Your Plan contract also excludes coverage for benefits that would be payable under any personal injury protection, MedPay, uninsured or underinsured motorist coverage, or Workers' Compensation you may have. Therefore, The Plan will also have the right to be reimbursed for any medical benefits from the proceeds of any personal injury protection, MedPay, uninsured, underinsured motorist coverage, or Workers' Compensation coverage applicable to this incident.

Please contact us prior to settlement.

I agree that any property/casualty, automobile, or workers' compensation carrier or governmental agency may release any personal health information about me related to this accident to Calypso Healthcare Solutions, an independent company responsible for providing subrogation services to Premera Blue Cross. This authorization is valid during the subrogation process.

I certify that the information on this form is true and accurate to the best of my knowledge.

Member *(please print)* _____ Phone _____

Signature _____ Date _____

Please submit completed form by:

- Fax: 425-918-5878
- Mail: P.O. Box 327, MS 227; Seattle, WA 98111

If you have any questions or need assistance, please contact Customer Service, 800-722-1471.