PREMERA | BLUE CROSS

P.O. Box 327, Mail Stop 227
Seattle, WA 98111-0327

Incident Questionnaire

Customer Service: 800-345-6784
Hearing-Impaired: 800-842-5357
FAX: 425-918-5878

Subscriber ID#: _____

Patient: _____

Patient Date of Birth: ____/____/____

_____ Group #: _____

_____ Date(s) of Service: _____

_____ Provider: _____

Diagnosis Code(s): _____

Dear Subscriber:

The above-listed service indicates that you may have been involved in an accident or have sustained an injury. In order to proceed with the processing of your health care claims, we need your help. Please return this form within 45 days with complete answers to all questions **ON BOTH SIDES.** THIS CLAIM CANNOT BE PROCESSED UNTIL THIS INCIDENT QUESTIONNAIRE IS **FULLY COMPLETED, SIGNED AND RETURNED.** When we receive the completed questionnaire, we'll process your claim within 15 days. **FAILURE TO RETURN THE COMPLETED QUESTIONNAIRE WITHIN 45 DAYS WILL RESULT IN DENIAL OF THE CLAIM(S).** Thank you for your prompt attention. We appreciate your assistance in providing this information so that we may complete the processing of your claim(s). Please return this form to the address listed above.

1 **If this injury or condition was not the result of an accident, please describe how you sustained the condition:**

_____

2 **Date of injury or onset of condition:** _____ Time: _____ ❑ AM ❑ PM

Type of injury/condition sustained: _____

_____

Names of any other family members injured: _____

Address or location where injury/onset of condition occurred: _____

_____

Do you own this property? ❑ Yes ❑ No *If No, go to # 3. If Yes, skip to # 4.*

3 **Did the injury or onset occur on another party's property?** ❑ Yes ❑ No *If No, skip to # 4.*

Is this property a rented home or apartment? ❑ Yes ❑ No *If Yes, skip to # 4.* ***If No, please provide:***

Location Name: _____ ❑ School ❑ Homeowner's Residence ❑ Business ❑ Other

Owner/Representative: _____ Phone: _____ Address: _____

Location's Insurance Company Name: _____ Policy #: _____

Adjuster or Agent Name: _____ Phone: _____ Claim #: _____

4 **Was the injury/condition sustained while performing work required for employment?** ❑Yes ❑No *If No, skip to # 5*

Is the injured person covered by Workers Compensation Insurance? ❑Yes ❑No

If No, please explain: _____

Are you self-employed? ❑Yes ❑No Do you have 24-hour coverage? ❑Yes ❑No

Has a Workers Compensation claim been filed? ❑Yes ❑No *If Yes, please provide Claim #* _____

Was a Workers Comp. claim denied? ❑Yes ❑No *If yes, please attach a copy of the denial.* Will you appeal? ❑ Yes ❑ No

5 **Did the injury/onset occur in, on or near a snowmobile, boat or personal watercraft?** ❑ Yes ❑ No *If No, Skip to # 6.*

Description of motorized craft: _____ I was a: ❑ Driver/Pilot ❑ Passenger ❑ Bystander

Does the owner of this motorized craft have medical payment coverage? ❑ Yes ❑ No ***If Yes, please provide:***

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5 **(continued)**

(This information will appear on your insurance premium bill or declarations page.)

Owner's Name: _____ Phone: _____ Address: _____

Insurance Company Name: _____ Policy #: _____

Address: _____

Adjuster or Agent Name: _____ Phone: _____ Claim # _____

6 **Did the injury occur in, on or near a motor vehicle?** ❑ Yes ❑ No *If No, skip to #7.* ***Please provide:***

I was a: ❑ Driver ❑ Passenger ❑ Pedestrian ❑ Bicyclist

* If passenger, did the car you were in carry Personal Injury Protection or Medical Payments provision? ❑Yes ❑No

Required: YOUR Auto Insurance Company Name: _____ Policy #: _____

Address: _____

Adjuster or Agent Name: _____ Phone: _____ Claim # _____

Does your automobile coverage include Personal Injury Protection or other Medical Payment provisions? ❑ Yes ❑No

("Personal Injury Protection" or "PIP" or "Medical Payments" will appear on your wallet card, bill or your policy's declarations page.)

6a **If you were the driver, did you own the vehicle?** ❑ Yes ❑ No ***Please provide:***

OWNER'S Name: _____ Phone: _____ Address: _____

OWNER'S Auto Insurance Company Name: _____ Policy #: _____

Address: _____

Adjuster or Agent Name: _____ Phone: _____ Claim # _____

Does your automobile coverage include Personal Injury Protection or other Medical Payment provisions? ❑ Yes ❑No

("Personal Injury Protection" or "PIP" or "Medical Payments" will appear on your wallet card, bill or your policy's declarations page.)

6b **Was another vehicle involved?** ❑ Yes ❑ No ***Please provide:***

OTHER DRIVER'S Name: _____ Phone: _____ Address: _____

OTHER DRIVER'S Auto Insurance Company Name: _____ Policy #: _____

Address: _____

Adjuster or Agent Name: _____ Phone: _____ Claim # _____

6c **Did the police investigate?** ❑ Yes ❑No *If Yes, was anyone cited?* _____ Case #: _____

Have you received a settlement? ❑ Yes ❑ No *If Yes, what was the date of the settlement?* _____

7 **Will you pursue a liability claim against another party?** (I.e., Auto, Medical Malpractice, Slip and Fall, Product Liability, Product recall, Home/Business, etc.) ❑ Yes ❑No ***If Yes, describe:*** _____

_____

8 **Have you retained an attorney regarding this injury/incident?** ❑ Yes ❑ No ***Please provide:***

Attorney's Name: _____ Phone: _____

Address: _____

*** PLEASE READ AND SIGN ***

Your health benefit plan (Plan) includes a Subrogation provision. Subrogation means the Plan has the right to be reimbursed for benefits paid under your contract for medical services incurred as a result of an incident for which another party is liable or for which you have other coverage such as PIP or UM/UIM (uninsured or under-insured motorist). The Plan can recover from you and/or another party. **Please contact us prior to any settlement.**

As required by my contract, I agree to reimburse the Plan for the amount it has paid if recovery is made from the party that is liable or from another first party payer. I understand that any person who knowingly (and with intent to injure, defraud or deceive an insurance company) files a claim containing false, incomplete and/or misleading information may be prosecuted under state law.

_____ _____

Signature of Subscriber (required) ***Signature of Injured Party***

_____ _____ _____

Phone Number (day) ***Phone Number (evening)*** ***Date***