

Member Name and Address

Today's Date _____
Patient Name _____
Patient Date of Birth _____
Member ID Number _____
Group Number _____
Provider _____
Service Date(s) _____

Dear Member:

IMPORTANT! Failure to return the questionnaire will result in claim(s) denial, and could also result in personal responsibility for the charges.

- The above-listed service indicates you may have been involved in an accident or sustained an injury.
- An extension to make a claim determination is needed because additional information is required. **Please complete, sign and return this form to the address above within 45 days.** A claims decision will be made within 15 days of receipt of this questionnaire.
- This claim cannot be processed until this incident questionnaire is fully completed, signed and returned.
- Responses left "blank" or "N/A" may result in claims being delayed or denied.
- If no specific accident occurred, or this is not work-related or motor vehicle accident related, you may contact customer service at the number listed above.

1. Cause of Injury or Condition:

- No Incident — *Describe how you sustained the condition:* _____
- Work-Related Snowmobile/Boat/Personal Watercraft Motor Vehicle Motorcycle – Street Bike Motorcycle – Dirt Bike
- Other Incident — *Describe how the accident, injury or illness occurred:* _____

The following information is REQUIRED for all incidents.

Please answer the following:

Date of accident, injury or condition / /		Names of covered family members injured	
Type of injury or condition sustained		Address or Location where injury/onset of condition occurred	
Do you own this property? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, skip to question #2.</i>			
<i>If No, (the incident occurred on another party's property) is this property a rented home or apartment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, please answer the following:</i></i>			
Location Name		Location Type <input type="checkbox"/> School <input type="checkbox"/> Homeowner's Residence <input type="checkbox"/> Business <input type="checkbox"/> Other	
Location Owner/Representative Name	Phone Number	Address/City/State/ZIP	
Location's Insurance Company Name		Address/City/State/ZIP	
Adjuster/Agent Name	Phone Number	Policy Number	Claim Number
Does the location's policy have a Medical Premises coverage provision? <input type="checkbox"/> Yes <input type="checkbox"/> No		Has a claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2. If you checked "Work-Related", please answer the following:

- Is the injured person covered by Workers' Compensation Insurance? Yes No *If No, please explain:* _____
- Are you self-employed? Yes No Are you an owner or sole proprietor? Yes No
- Has a Workers' Compensation claim been filed? Yes No *If Yes, please provide claim number:* _____
- Was a Workers' Compensation claim denied? Yes No *If Yes, please attach a copy of the denial.* Will you appeal? Yes No

3. If you checked "Snowmobile/Boat/Personal Watercraft", please answer the following:

I was a: <input type="checkbox"/> Driver/Pilot <input type="checkbox"/> Passenger <input type="checkbox"/> Bystander		Description of motorized craft	
OWNER'S Name	Phone Number	Address/City/State/ZIP	
Motorized Craft Insurance Company Name		Address/City/State/ZIP	
Adjuster/Agent Name	Phone Number	Policy Number	Claim Number
Does the owner have Medical Payment coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the owner have Uninsured/Under-insured Motorist coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	

4. If you checked "Motor Vehicle" or "Motorcycle", please answer the following:

I was a: Driver Passenger Pedestrian Bicyclist *The following information is REQUIRED for all motor incidents, please complete:*

YOUR Auto Insurance Company Name		Address/City/State/ZIP	
Adjuster/Agent Name	Phone Number	Policy Number	Claim Number
Does your coverage include Personal Injury Protection (PIP) or other Medical Payment (MedPay) provisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Look for "Personal Injury Protection" / "PIP" or "Medical Payments" / "MedPay" on your policy's declarations page.)</i>			
Do you have Uninsured/Under-insured Motorist coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			

4a. If you were a passenger, did the driver of the car you were in carry PIP or other MedPay provisions? Yes No

4b. If you were the driver, did you own the vehicle? Yes No *If No, please answer the following:*

OWNER'S Name	Phone Number	Address/City/State/ZIP	
OWNER'S Auto Insurance Company Name		Address/City/State/ZIP	
Adjuster/Agent Name	Phone Number	Policy Number	Claim Number
Does the owner's coverage include PIP or other MedPay provisions? <input type="checkbox"/> Yes <input type="checkbox"/> No			

4c. Was another vehicle involved? Yes No *If Yes, please answer the following:*

OTHER DRIVER'S Name	Phone Number	Address/City/State/ZIP	
OTHER DRIVER'S Auto Insurance Company Name		Address/City/State/ZIP	
Adjuster/Agent Name	Phone Number	Policy Number	Claim Number
If no claim filed, do you plan to file a claim? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, please explain:</i>			

4d. Did the police investigate? Yes No *If Yes, were you cited?* Yes No *If Yes, please provide case number:* _____

4e. Have you received a settlement? Yes No *If Yes, what was the date of the settlement?* _____ / _____ / _____
With whom did you settle? Your own insurance company Another party's insurance company Your uninsured/under-insured policy

5. Will you pursue a liability claim against the other people involved? (i.e., Auto, Medical Malpractice, Slip and Fall, Product Liability, Product Recall, Home/Business, etc.)

Yes No *If Yes, please describe:* _____

6. Have you retained an attorney regarding this injury/incident? Yes No *If Yes, please answer the following:*

Attorney's Name	Phone Number	Address/City/State/ZIP
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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 any recovery is made from the party that is liable or from my other coverage. I also agree that any property/casualty or automobile insurer 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.

Signature of Subscriber _____ Signature of Injured Member _____

Subscriber's Name (please print) _____ Injured Member's Name (please print) _____

Subscriber's Phone Number (Day) _____ (Evening) _____ Date ____ / ____ / ____

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.