PREMERA BLUE CROSS

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

Incident Questionnaire

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

Today's Date _____

Patient Name _____

Patient Date of Birth _____

Member ID Number _____

Group Number _____

EDMONDS ORTHOPEDIC CENTER

Provider _____

Service Date(s) _____

Diagnosis Code(s) _____

Dear Member:

IMPORTANT! Failure to return the questionnaire will result in denial of the claim(s) which could result in you being responsible 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? ☐ Yes ☐ No ***If Yes,*** skip to question #2.
If No, (the incident occurred on another party's property) is this property a rented home or apartment? ☐ Yes ☐ No ***If No, please answer the following:***

Location Name		Location Type ☐ School ☐ Homeowner's Residence ☐ Business ☐ 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? ☐ Yes ☐ No Has a claim been filed? ☐ Yes ☐ 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: ☐ Driver/Pilot ☐ Passenger ☐ 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? ☐ Yes ☐ No Does the owner have Uninsured/Under-insured Motorist coverage? ☐ Yes ☐ 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? ☐ Yes ☐ No *(Look for "Personal Injury Protection" / "PIP" or "Medical Payments" / "MedPay" on your policy's declarations page.)*			
Do you have Uninsured/Under-insured Motorist coverage? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No ***If No***, please explain:				

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

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 the Plan's subrogation affiliate, Calypso. 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.*