INCIDENT REPORT

Regence BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

1800 Ninth Avenue • P.O. Box 21267
Seattle, Washington 98111-3267 • 206 464-3663
In State 1-800-458-3523 • Out of State 1-800-544-4246

PLEASE COMPLETE THE FOLLOWING QUESTIONS

	PATIENT NAME
	ID NO.
	INJURY DATE
	DATE(S) OF SERVICE
EDMONDS ORTHOPEDIC CENTER	PROVIDER OF SERVICE

WE NEED YOUR HELP!

According to our information, the treatment received on the date(s) specified above may have been the result of an injury or accident. We need additional information to complete the processing of this claim. Without this information, claims may be denied or paid incorrectly. Please complete this form and return it within 45 days of receipt. When additional information is required and claims are held for return of that information, we may extend the overall time taken to process the claim to include an additional 15 days.

BRIEFLY DESCRIBE THE CIRCUMSTANCES THAT CAUSED YOU TO SEEK TREATMENT.

If these circumstances relate to a specific incident or event, please complete the following questions.

Date of Incident or Event / /	Time AM PM	Date Treatment Provided / /	Time AM PM	Location of Incident or Event

Please describe your injuries or medical condition in detail.

PLEASE COMPLETE THE BLOCK OF QUESTIONS BELOW WHICH RELATES TO YOUR TREATMENT

1. WAS TREATMENT THE RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ Yes (please give details below) ☐ No

The patient was a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other _____

The vehicle was a: ☐ Car ☐ Motorcycle ☐ Other _____

Name of Responsible Party		Responsible Party's Drivers License Number
Responsible Party's Insurance Company	Insurance Company's Address	
Adjuster's name	Adjuster's Telephone Number	Claim Number
Do you have vehicle insurance? ☐ Yes ☐ No	Is there medical coverage under your vehicle insurance? ☐ Yes ☐ No	
Name of Your Insurance Company	Your Insurance Company's Address	
Adjuster's Name	Adjuster's Telephone Number	Claim Number
Name(s) of Other Family Member(s) Injured		

Please attach photocopy of the insurance policy page that states the monetary amounts of the coverage relating to this incident.

2. DID THIS MEDICAL CONDITION OCCUR ON THE JOB? ☐ Yes (please give details below) ☐ No

If yes, enter the Worker's Compensation Claim Number	Are you a police officer or firefighter under LEOFF-1? ☐ Yes ☐ No

If your claim was denied, attach a copy of the denial.

3. DID THE MEDICAL CONDITION occur ON SOMEONE ELSE'S PROPERTY? ☐ Yes (please give details below) ☐ No

If yes, Address of Location		Did the incident occur on public property? ☐ Yes ☐ No
Name of Responsible Party		Responsible Party's Insurance Company
Adjuster's Name	Adjuster's Telephone Number	Claim Number

4. HAVE YOU RETAINED AN ATTORNEY TO PURSUE YOUR PERSONAL DAMAGES? ☐ Yes (please give details below) ☐ No

Name of Attorney Representing You	Attorney's Telephone Number
Attorney's Address	

PLEASE READ AND SIGN THE REVERSE SIDE

Your Regence BlueShield contract includes a subrogation provision. "Subrogation" means that if Regence BlueShield makes any payments on your behalf for injuries caused by another party who may be liable for those injuries, Regence BlueShield is entitled to recover those payments from the other party. As a condition of these payments, the subscriber agrees to cooperate with Regence BlueShield in its efforts to recover the cost paid on behalf of the injured party.

I understand that if I or any of my dependents have been injured by another party, the benefits of my contract will be available to the injured person, subject to the exclusions and limitations of the contract. I agree to cooperate with Regence BlueShield in its subrogation and reimbursement rights as stated in the contract. Regence BlueShield reserves the right to determine payment of attorney fees for recovery of its financial interest in this claim. I understand I am not entitled to keep that portion of the settlement which represents reimbursement of the amount Regence BlueShield paid towards my medical benefit except as determined by applicable law.

I hereby authorize Regence BlueShield and anyone acting on behalf of it, to release any information about my accident and the benefits and medical services I received in connection with my accident to any persons who may be liable to me or Regence BlueShield, and to the insurance company of any such person or to any insurance company that provides coverage for injuries related to this accident. I further authorize my insurance company to release any information concerning my coverage to Regence BlueShield.

I also authorize Regence BlueShield to review any workers' compensation claims files pertaining to me so that Regence BlueShield can determine whether workers' compensation coverage is available for any of my injuries.

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

Subscriber Signature	Date	Subscriber Social Security Number

Address	Home Telephone Number
	Work Telephone Number