PREMERA | BLUE CROSS

PO Box 21731
Eagan, MN 55121-0731

Incident Questionnaire

Complete this form so your claim can be paid

Your claim is denied until this form is completed and returned.

Premera Blue Cross requires an Incident Questionnaire when you have a claim and the treatment or condition has diagnoses that could be related to an incident or accident. This will help determine if any other parties (such as auto insurance) can help pay for your care.

Please complete the attached Incident Questionnaire so your benefits can be paid correctly.

Next steps:

1. Complete Section A General information in the form to give us more details about your injury or condition.
2. Next, complete any other required sections based on your responses.
3. Sign and date the form in Section E.

If we don't hear from you:

You will be responsible for some or all the costs of your care.

Send completed form via:

Email us through your Secure Inbox:
Sign in to your account at premera.com and select Secure Inbox. Scan and send this completed form and any required documents back to us as a secure email attachment.

— OR —

Fax: 425-918-5878

— OR —

Mail:
Premera Blue Cross
PO Box 21731
Eagan, MN 55121-0731

A decision will be made no later than 30 days after the Incident Questionnaire has been received. We may contact you if the form is not sufficiently filled out.

Thank you,
Claims Department
Premera Blue Cross

Questions?
Call the customer service number on the back of your Premera member ID card.

PREMERA | BLUE CROSS

Subscriber Name and Address	

Patient First, Last Name	
Member ID	
Date of birth	
Provider name	
Date of service	
Claim number (if known)	

Section A. General information (required)

Date incident/accident occurred

Was this claim related to an incident? Select one.

❍ Yes. ❍ No. Complete this section then skip to Section E.

This claim is related to the following: Select one.

❍ Work incident or illness. Complete Section B.
❍ Motorized vehicle incident, including in, on, or around a vehicle, such as watercraft, ATV, or automobile. Complete Section C.
❍ Other. Complete Section D.

Describe what happened and where the incident/accident took place, including the state where it happened. If you run out of room below, please attach a separate document with your full written description when you submit this form.

Describe all body parts injured and the nature of the injuries (such as broken right wrist) for yourself and any family members involved. If you run out of room below, please attach a separate document with your full written description when you submit this form.

Patient's attorney's name (if applicable)		Phone - include area code	
Mailing address	City	State	Zip code

Section B. Complete this if you checked "Illness or work incident" in Section A.

1. Select all that apply.
☐ I am self-employed.
☐ I am an owner or sole proprietor.
☐ I have worker's compensation coverage. If yes, complete Section B2.

2. Did you file a claim? Select one.

❍ Yes. ❍ No. Skip to Section E.

What is the claim status? Select one.

❍ In review ❍ Accepted liability
❍ Denied liability. Please include a copy of the denial letter with your claim.
❍ Appeal denied. Please include a copy of the denial letter with your claim.

	Worker's compensation carrier		Worker's comp claim number	
	Adjuster's name		Phone - include area code	
	Mailing address	City	State	Zip code
Section B completed? Go to Section E to finish the form.				

Section C. Complete this if you checked "Motorized vehicle incident" in Section A.

1.	The patient was a (select one)			
	❍ Passenger		❍ Bicyclist	
	❍ Driver		❍ Pedestrian	
2.	Does the patient have vehicle insurance? ❍ Yes ❍ No. Skip to Section C4.	Does coverage include personal injury protection (PIP) or other medical payment (MedPay) provisions? Look for "personal injury protection (PIP)" or "medical payments (MedPay)" on your policy's declarations page. ❍ Yes ❍ No		
3.	Patient's vehicle insurance carrier's name		Policy number	Claim number
	Adjuster's name	Phone - include area code		
4.	Mark the true statement. Select one.			
	❍ The patient did not own the vehicle.	❍ The patient owned the vehicle. Skip to Section C7.		
5.	Does the vehicle owner have vehicle insurance? ❍ Yes ❍ No. Skip to Section C6.	Does the vehicle owner's coverage include personal injury protection (PIP) or other medical payment (MedPay) provisions? ❍ Yes ❍ No		
	Owner's name			
	Owner's vehicle insurance carrier's name		Policy number	Claim number
	Adjuster's name			Phone - include area code
6.	Was another vehicle involved? Select one. ❍ Yes ❍ No. Skip to Section C10.			
7.	Other driver's name			
8.	Have you filed an insurance claim with the other driver or do you anticipate doing so? Select one. ❍ Yes ❍ No. The other driver does not have insurance. Skip to Section C11. ❍ No. Skip to Section C11.			
9.	Other driver's vehicle insurance carrier's name			
	Adjuster's name	Phone number – include area code		
	Policy number	Claim number		

10.	Has the patient received a bodily injury settlement? Select one. ❍ Yes ❍ No. Skip to Section E.	Settlement date
	With whom did patient settle? Select one. ❍ Patient's insurance company ❍ Another party's insurance company ❍ Patient's uninsured/under-insured policy	
Section C completed? Go to Section E to finish the form.		

Section D. Complete this if you checked "Other" in Section A.

1.	Did the incident occur on property you own? Select one. ❍ Yes. Skip to Section E. ❍ No			
2.	Have you filed an insurance claim with the at-fault party or do you anticipate doing so? ❍ Yes ❍ No. Skip to Section E.			
	At-fault party's name (only required if you choose to file a claim)			
	Policy number	Claim number		
	At-fault party's insurance carrier's name		Phone - include area code	
	Insurance carrier's mailing address	City	State	Zip code
Section D completed? Go to Section E to finish the form.				

Section E. Signature – Please read and sign.

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 under-insured 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, under-insured 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 incident 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 or patient X_____	Printed name	
	Daytime phone - include area code	Date signed (mm/dd/yyyy)

Notice of availability and nondiscrimination **800-722-1471 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທ່ເໝາະສົມແບບບ່ເສຍຄ່າ.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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