LIFEWISE | HEALTH PLAN OF WASHINGTON

The LifeWise Health Plan of Washington Incident Questionnaire (IQ) is required when you have a claim and the treatment or condition has diagnoses that could be related to an accident. We need this information to determine if there are any other parties liable, such as auto/worker compensation coverage.

Following the instructions below will expedite claims processing.

1. Please type or neatly print all answers.

2. Complete each information line located in the upper right-hand corner of the form so we may identify you and your claim.

3. Complete sections A-F, making sure to indicate the cause of your injury or condition in section A.

4. Don't forget to sign and date the form in section F.

5. **Fax** this completed form to 425-918-5878 or

   Mail this completed form to:
   LifeWise Health Plan of Washington
   PO Box 327, Mail Stop 227
   Seattle, WA 98111-0327

Note: You have 45 days to complete, sign and return the IQ form from the date it was requested. If you do not return the completed form within this required time period, your claim(s) will be denied.

If you have any questions or need assistance, please contact our Customer Service Department at 800-592-6804.

LIFEWISE | HEALTH PLAN OF WASHINGTON

M.S. 227
P.O. Box 327
Seattle, WA 98111

Incident Questionnaire

Customer Service: 800-592-6804
Hearing Impaired: 800-842-5357
Fax: 425-918-5878

Patient name and address:

Today's date _____
Patient name _____
Patient date of birth _____
Member ID number _____
Group number _____
Provider name _____
Date of service _____

Failure to return the questionnaire will result in claim(s) denial, and could also result in personal responsibility for charges. This claim cannot be processed until this incident questionnaire is fully completed, signed and returned.

FOLD HERE →

A. General Information

▼ Was this claim related to an **incident/accident**?

☐ **No**	If you checked "No," please describe what happened and where it occurred (required): ☐ **Gradual Onset** *Thank you for your information. Please skip to **section F** and sign & date this form.*
☐ **Yes**	Date incident/accident occurred: _____ If you checked "Yes," please continue to **section B.**

B. Incident/Accident Information

This claim is related to (please check the appropriate box):
☐ Work incident/accident or illness
☐ Motorized vehicle incident/accident, select one: ☐Automobile ☐Street Bike ☐Dirt Bike ☐Watercraft ☐Snowmobile
☐ Other type of incident/accident → describe:

Describe how the incident/accident happened, including the location and state

State all parts of body and type of injuries involved (e.g., bruised left knee)

List any other family members involved in the incident/accident and their injuries:

STOP ***Complete the appropriate sections below, and then skip to section F to sign & date form.***

FOLD HERE →

C. Complete if you checked "WORK INCIDENT/ACCIDENT OR ILLNESS" in section B

Are you self-employed? ☐ No ☐ Yes | Are you an owner or sole proprietor? ☐ No ☐ Yes

Do you have workers' compensation coverage? ☐ No ☐ Yes If yes, did you file a claim? ☐ No ☐ Yes

Workers' Compensation carrier and adjuster's name:	Phone number	Address/City/State/ZIP

What is the status of the Workers' Compensation claim?
☐ In review ☐ Denied liability*
☐ Accepted liability ☐ Appealing denial*

Worker's compensation claim number (required):
**** If a Workers' Compensation claim has been filed and denied, please include a copy of the denial letter.***

Patient's attorney name (if applicable)	Phone number	Address/City/State/ZIP

STOP ***After completing sections A, B & C, skip to section F to sign & date form.***

D. Complete if you checked "AUTOMOBILE OR MOTORCYCLE INCIDENT/ACCIDENT" in section B

The patient was a: ☐ Driver ☐ Passenger ☐ Bicyclist ☐ Pedestrian

Patient's auto insurance carrier's name	Address/City/State/ZIP		
Adjuster's name	Phone number	Policy number	Claim number

Does this coverage include Personal Injury Protection (PIP) or other Medical Payment (MedPay) provisions? ☐ **No** ☐ **Yes**
Look for "Personal Injury Protection (PIP)" or "Medical Payments (MedPay)" on your policy's declarations page.
Do you have Uninsured/Underinsured (UM/UIM) coverage? ☐ **No** ☐ **Yes**

IF PATIENT WAS the passenger of the car, do they carry PIP or other MedPay provisions? ☐ No ☐ Yes

▼ **IF PATIENT** did not own the vehicle, complete the following:

OWNER's name			
OWNER's auto insurance carrier's name	Policy number	Claim number	Does the owner's coverage include PIP or other MedPay provisions? ☐ No ☐ Yes

▼ **IF ANOTHER VEHICLE WAS INVOLVED,** complete the following:

OTHER DRIVER'S auto insurance carrier's name	Policy number	Adjuster's name	Adjuster's Phone number
OTHER DRIVER'S name	Insurance carrier Address/City/State/ZIP		Claim number

If no claim filed, do you plan to file a claim? ☐ No ☐ Yes → explain why not:

▼ **ADDITIONAL INFORMATION**

Has patient received a bodily injury settlement? ☐ No ☐ Yes → date of settlement:
With whom did patient settle? ☐ Patient's insurance company ☐ Another party's insurance company ☐ Patient's uninsured/under-insured policy

Patient's attorney name (if applicable)	Address/City/State/ZIP	Phone number

After completing sections A, B & D, skip to section F to sign & date form.

E. Complete if you checked "OTHER TYPE OF INCIDENT/ACCIDENT" in section B

Did the incident/accident occur on property you own? ☐ No→ complete the rest of this section ☐ Yes→ skip to section F

Is there Medical Premise coverage on the property where the incident/accident occurred? ☐ No ☐ Yes
If yes, will you file a claim? ☐ No ☐ Yes
Have you filed an insurance claim with the at-fault party or do you anticipate pursuing a claim?
(Medical malpractice, slip & fall, product liability, product recall, home/business, assault, etc.) ? ☐ No ☐ Yes
If no, why?

At-fault party's insurance carrier's name (if known)	Insurance carrier's Address/City/State/ZIP	Insurance carrier's phone number
At-fault party's name	Policy number	Claim number
Patient's attorney name	Address/City/State/ZIP	Phone number

F. PLEASE READ AND SIGN

Your health benefit plan (the 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.

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.

Patient or Subscriber signature **X**	Printed name	Daytime phone number	Date signed

Upon completion of this form, please fax or mail it back to us within 45 days of the requested date.