

The Premera Blue Cross 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:
Premera Blue Cross
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 800-722-1471.

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.

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:



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

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
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What is the status of the Workers' Compensation claim? <input type="checkbox"/> In review <input type="checkbox"/> Denied liability* <input type="checkbox"/> Accepted liability <input type="checkbox"/> 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.
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Patient's attorney name (if applicable)	Phone number	Address/City/State/ZIP
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After completing sections A, B & C, skip to section F to sign & date form.

FOLD HERE →

FOLD HERE →

D. Complete if you checked "AUTOMOBILE OR MOTORCYCLE INCIDENT/ACCIDENT" in section BThe 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 YesIf 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 Calypso Healthcare Solutions, an independent company responsible for providing subrogation services to Premera Blue Cross. 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 Printed name Daytime phone number Date signed

X

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