



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield  
1800 Ninth Avenue  
Seattle, WA 98101  
1 (888) 367-2112

Please return the completed form.

By Mail: PO Box 12625 MS S1C  
Salem, OR 97309  
By Fax: 1 (888) 891-0771

Today's Date:  
ID Number:  
Patient:  
Claim Number:  
Provider:  
Date of Service:  
Client Letter ID:

## Incident Report

Please complete this Incident Report and return it in the enclosed envelope within 45 days of receipt. If we do not receive your complete and signed Incident Report within forty-five days, all claims related to this incident will be denied until the Incident Report is received. Please be aware that if claims are denied due to tardiness in returning your completed Incident Report, charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

Complete information is essential and very much appreciated. When additional information is required, claims cannot be processed. It will take up to 15 days after we receive all necessary information before claims can be processed. To avoid delays, carefully and completely provide all requested information.

### GENERAL INFORMATION

**Briefly explain why you sought treatment. Please identify the specific body area(s) affected by this injury, if applicable. How did the injury occur? What was injured? Where did the event occur?**

Date of injury or onset of illness \_\_\_\_\_ Explanation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Was the service received for the injury described above related to an incident that occurred:**

- At work or on the job; or
- Due to an auto accident or auto-related injury; or
- Due to an Other Vehicle Accident (motorcycle, scooter, snowmobile, boat, etc. accident); or
- Caused by another party; or
- Caused by something/someone at a business or residence other than your own home?

**The service received from the injury described above:**

- Was not incurred at work or on the job; or
- Was not caused by another party or incurred as the result of an accident; or
- No other person was involved. Please explain above.

**If the injuries you sustained were not related to an accident or incurred at work or on the job, please skip to the end of this form and sign, date and return it to us.**

**Otherwise, please continue on and complete the applicable section(s) on pages 2 and 3, then sign, date and return the form.**



**GENERAL INFORMATION (continued)**

**Do you intend to seek recovery for damages from the party responsible for the accident, injury or work-related condition?**  Yes  No

Have you been offered a settlement?  Yes  No

Have you accepted a settlement?  Yes  No

If Yes, date of settlement \_\_\_\_\_ Amount of settlement \_\_\_\_\_

**Please include a copy of your settlement documents**

**Have you hired an attorney?**  Yes  No

Attorney's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Attorney's Address \_\_\_\_\_

**Was the treatment a result of an auto/other type of vehicle injury/accident?**

Yes (please give details below)  No

The patient was a:  Driver  Passenger  Pedestrian  Other

The vehicle was a:  Car  Motorcycle  ATV  Snowmobile  Other

Were there more than two vehicles involved?  Yes  No

Name of the At-Fault Party \_\_\_\_\_

At-Fault Party's Insurance Company \_\_\_\_\_

At-Fault Party's Insurance Company's Address \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Adjuster's Phone Number \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjuster's E-mail Address \_\_\_\_\_

Do you have vehicle insurance?  Yes  No \*If No, attach a copy of police report.

**Is there Personal Injury Protection (PIP) or Medical Payments (Med-Pay) under your vehicle insurance?**

Yes  No Please attach a photocopy of your insurance policy declaration page that shows what types of coverage you have (in particular, whether your policy provides PIP or Med-Pay coverage) and the monetary amount of your coverage.

Name of your Insurance Company \_\_\_\_\_

Insurance Company's Address \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Adjuster's Phone Number \_\_\_\_\_

Claim Number \_\_\_\_\_ Adjuster's E-mail Address \_\_\_\_\_

Name of other family member(s) covered on your health plan that were injured \_\_\_\_\_



**GENERAL INFORMATION (continued)**

If accident was not in your own vehicle, name and address of owner of vehicle in which patient was traveling.

Insurance Company, Claim Number, Adjuster's Name and Phone Number for vehicle in which patient was traveling.

Did this vehicle policy have PIP or Med-Pay benefits for passengers?  Yes  No

**\*If PIP/Med-Pay is exhausted, please provide copy of auto insurance payment ledger.**

**WORK-RELATED CONDITION**

**Was the service you received necessitated by an injury, condition, or illness caused or received at work or on the job?**  Yes  No

If Yes, please tell us what happened \_\_\_\_\_

When (or over what period of time) did you incur your injury or illness \_\_\_\_\_

Have you filed a claim with Workers' Compensation?  Yes  No

If Yes, please provide: Claim Number \_\_\_\_\_

Workers' Compensation Carrier Name, Address \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Adjuster's Phone Number \_\_\_\_\_

**\*If your claim was denied or closed, please attach a copy of your closure notice or denial.**

Do you plan to appeal this decision?  Yes  No

Are you self-employed?  Yes  No

If Yes, do you carry an industrial policy for yourself?  Yes  No

Name and Address of Industrial carrier (if applicable) \_\_\_\_\_

Are you a police officer or firefighter under LEOFF-1?  Yes  No

**OTHER ACCIDENT OR INJURY**

Did the accident or injury occur on someone else's property?  Yes  No

Do the property owners have insurance to cover medical expenses?  Yes  No

Do you intend to file a claim?  Yes  No

If Yes, please provide the name of the insurance company \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Claim Number \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_



**SUBSCRIBER'S STATEMENTS**

I understand that if I, or any of my covered dependents ("Subscriber") have been in an accident or have been injured by another party, or have work-related condition, the benefits of my health benefit plan will be available to me or my covered dependents, subject to the terms, limitations, and exclusions of the plan. The Subscriber further understands that, as a condition of coverage, the health benefit plan requires the Subscriber to cooperate with Regence BlueShield (Regence) in its efforts to recover the cost of benefits it has provided from the responsible party or the responsible party's insurer, and that if the Subscriber does not cooperate in full accordance with the health benefit plan, that Regence may pursue reimbursement from the responsible party, or the responsible party's insurer, or from the Subscriber in accordance with the health benefit plan and applicable law.

The Subscriber understands that Regence and anyone acting on its behalf is permitted by law to release information about any accident, injury, or work-related condition described on this Incident Report and the benefits and medical service the Subscriber received in connection with that accident, injury, or work-related condition to any potentially responsible party and the potentially responsible parties' insurer.

The Subscriber authorizes the insurance company(ies) listed on pages 2 and 3 to release any information concerning the Subscriber's coverage to Regence. The Subscriber further authorizes Regence to review the Subscriber's workers' compensation claims files pertaining to this Incident Report so that Regence can determine whether workers' compensation coverage is available for any potential work-related condition.

The Subscriber understands that it is a crime to knowingly provide false, misleading, or incomplete information to Regence with the intent of defrauding the company, and that the penalties for committing fraud include imprisonment, fines and denial of insurance benefits. Moreover, Regence will have the right to pursue its legal rights, including the collection of claims payments and any other damages.

The Subscriber accordingly declares that the information on pages 1 through 3 is true, correct and complete.

**DATED and SIGNED on the** \_\_\_\_\_ **day of** \_\_\_\_\_ , 20\_\_\_\_\_ .

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ E-mail Address \_\_\_\_\_

Subscriber's Signature  \_\_\_\_\_

Date \_\_\_\_\_ ID Number \_\_\_\_\_

Injured Dependent/Guardian Signature  \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_

We may need to contact you further to clarify your answers or obtain additional information. Please include available times if there are time restrictions regarding when we should contact you. Also, please include your e-mail address if it's okay to contact you in that manner.

**Additional information/clarification** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

