PREMERA | BLUE CROSS

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-1234

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 accident or incident. 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 the General information section 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 D.

If we don't hear from you:

You will be responsible for some or all of 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 327, MS 227
Seattle, WA 98111-0327

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.

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Subscriber first name | MI | Last name

Address

City | State | ZIP

Patient first name | Last name

Member ID

Date of birth

Provider name

Claim number (if known)

Date of service

General information (required)

Date incident/accident occurred:

Was this claim related to an incident?

◯ Yes ◯ No If No, complete the General information section, then skip to Section D.

This claim is related to the following:

☐ **Work incident or illness**
Complete Section A.

☐ **Motorized vehicle incident, including in, on, or around a vehicle, such as watercraft, ATV, or automobile**
Complete Section B.

☐ **Other**
Complete Section C.

Describe what happened and where it took place (including the state it happened in). 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.

Patient's attorney's name (if applicable) | Phone number

Address (if applicable)

City | State | ZIP

Section A — Complete if you checked "Work incident or illness"

✓ Completed this section? Skip to Section D.

◯ Yes ◯ No Are you self-employed?
◯ Yes ◯ No Are you an owner or sole proprietor?
◯ Yes ◯ No Do you have workers' compensation coverage?
◯ Yes ◯ No If yes, did you file a claim?

What is the claim status?

☐ In review ☐ Denied liability*
☐ Accepted liability ☐ Appeal denial*

***If a claim has been filed and denied, please include a copy of the denial letter.**

Workers' compensation carrier

Adjuster's name | Phone number

Address

City | State | ZIP

Workers' compensation claim number

Section B — Complete if you checked "Motorized vehicle incident"

✓ Completed this section? Skip to Section D.

Was the patient a: ☐ Passenger ☐ Bicyclist ☐ Pedestrian ☐ Driver

Please complete the following:

◯ Yes ◯ No 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.

Patient's auto insurance carrier's name (indicate if uninsured)

Adjuster's name | Adjuster's phone number

Policy number | Claim number

If the patient was not the driver and did not own the vehicle, complete the following:

◯ Yes ◯ No Does the owner's coverage include personal injury protection (PIP) or other medical payment (MedPay) provisions?

Owner's name (indicate if uninsured)

Owner's auto insurance carrier's name (indicate if uninsured)

Adjuster's name | Adjuster's phone number

Policy number | Claim number

If another vehicle was involved, complete the following:

◯ Yes ◯ No Have you filed an insurance claim with the other driver or do you anticipate doing so?

Other driver's name

Adjuster's name

Other driver's auto insurance carrier's name (if not applicable, indicate)

Adjuster's phone number

Policy number | Claim number

Additional information

◯ Yes ◯ No Has patient received a bodily injury settlement?

Settlement date:

With whom did the patient settle?

☐ Patient's insurance company

☐ Another party's insurance company

☐ Patient's uninsured/under-insured policy

Section C — Complete if you checked "Other"

✓ Completed this section? Skip to Section D.

◯ Yes ◯ No Did the incident occur on property you own?
If Yes, skip to Section D.
If No, complete the remaining section.

◯ Yes ◯ No Have you filed an insurance claim with the at-fault party or do you anticipate doing so?
If Yes, complete the remaining section.

At-fault party's name (only required if you choose to file a claim)

Policy number | Claim number

At-fault party's insurance carrier name | Phone number

Insurance carrier address

City | State | ZIP

Section D — 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.

Patient or subscriber signature | Printed name | Daytime phone number | Date signed

X

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 ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
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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