



**BLUE CROSS**

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

Member name

Address

City/State/ZIP

We need your help to  
process a claim

**Return within  
45 days**

We need information about your claim related to a medical visit.

This will help determine if any other parties (such as auto insurance), can help pay for your care. We cannot process your claim until the attached Incident Questionnaire form is fully completed, signed 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.

#### 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.
4. Return the completed Incident Questionnaire form within 45 days from the date of this letter.

#### If we don't hear from you

- Your claim(s) will be denied if you do not return the completed form within 45 days from the date of this letter.
- If your claim is denied, you may be responsible for some or all of the costs of your care.

#### Send completed form via:

**Email:**  
amazon@premera.com

**Secure inbox:**  
Sign in to your Premera account and select Secure Inbox under Manage My Account

**Fax:**  
425-918-5878

**Mail:**  
Premera Blue Cross  
PO Box 327, Mail Stop 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?

877-995-2696 (TTY: 711)  
Available 24/7, excluding holidays

We also welcome your feedback at  
premeralistens.com.

Patient name
Member ID
Date of birth
Provider name
Claim number (if known)
Date of service

Member name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

**General information (required)**

Yes  No **Was this claim related to an incident?**  
 If No, describe what happened, then skip to Section D.

Date incident/accident occurred: \_\_\_\_\_

**This claim is related to:**

**On-site work incident or illness**  
Complete Section A.

**Off-site work incident**  
Complete Sections A and B.

**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).  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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 (if applicable)  
 \_\_\_\_\_

Address/City/State/ZIP (if applicable)  
 \_\_\_\_\_

**Section A – Complete if you checked “Work incident or illness”**  Completed this section? Skip to Section D.

Yes  No **Are you self-employed?** Workers' compensation carrier and adjuster's name  
 \_\_\_\_\_

Yes  No **Are you an owner or sole proprietor?** \_\_\_\_\_

Yes  No **Do you have workers' compensation coverage?** Phone number  
 \_\_\_\_\_

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.

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.

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

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.

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.

Звертайте 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 ማሳሰቢያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ 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](mailto: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>.

