PREMERA HMO

Premera Blue Cross HMO
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 HMO 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 the costs of your care.

Send completed form via:

Fax:
425-918-5878

— OR —

Mail:
Premera Blue Cross HMO
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 HMO

Questions?

844-722-4661 (TTY: 711)
Monday through Friday
5 a.m. to 8 p.m. Pacific Time

We also welcome your feedback at premeralistens.com.

PREMERA HMO

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?

☐ 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 and 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 HMO (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 HMO. This authorization is valid during the subrogation process.

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

X

PREMERA HMO

Discrimination is Against the Law

Premera Blue Cross HMO (Premera HMO) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO provides free aids and services to people with disabilities 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 HMO provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 844-722-4661 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 844-722-4661（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-722-4661 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-722-4661 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-722-4661 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-722-4661 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 844-722-4661 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-722-4661 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。844-722-4661（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 844-722-4661 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 844-722-4661 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-722-4661 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844-722-4661 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-722-4661 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 844-722-4661 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 844-722-4661 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-722-4661 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-722-4661 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 844-722-4661 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-722-4661 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 844-722-4661 (TTY: 711) تماس بگیرید.