Regence BlueCross BlueShield of Oregon | Regence Life and Health Insurance Company

Independent Licensees of the Blue Cross and Blue Shield Association

INCIDENT REPORT

Sometimes additional information is required before we can complete the processing of your medical claims. The information you provide to us on this form will help us to resume claim processing. Please print this form and complete all applicable sections, whether your injury was the result of an accident or related to an illness.

Completed forms may be faxed to (503) 391-8622, or mailed to:

Regence BlueCross BlueShield of Oregon
PO BOX 12625 M/S S1C
Salem, OR 97309

If you need assistance completing this form, please contact the Customer Service Department at (800) 962-2732.

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Today's date:_____

Member Number: _____

Patient Name: _____

Claim Number(s): _____

Provider Name: _____

Date(s) of Service : _____

REPORT OF ACCIDENT, INJURY, OR WORK-RELATED CONDITION

Dear Member:
We have recently received claims for health care received by the above patient for what may be an accident, injury, work-related condition, or possibly the responsibility of another party. If this form is not completed and returned, we will have to deny all claims relating to this accident, injury, illness, or work-related condition, and you will be responsible for all charges.

General Information

Date of injury or illness onset _____ Briefly explain why you sought treatment, include the specific body area(s) affected by this injury, if applicable._____
_____
_____
_____

Was the above service related to an incident that occurred?

☐ At work or on the job ☐ Auto ☐ Motorcycle ☐ Caused by another party ☐ Other ☐ No accident

If no accident, sign, date and return form. Otherwise, complete the appropriate sections below, sign, date and return form.

HAVE YOU RETAINED AN ATTORNEY TO PURSUE YOUR PERSONAL DAMAGES? Yes☐ No ☐

Attorney's Name: _____ Phone No.
Attorney's Address:
_____

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

If Yes, have you been offered a settlement? _____ Yes ☐ No ☐

Have you accepted a settlement? Yes ☐ No ☐ If Yes, date of settlement: _____

WAS THE TREATMENT A RESULT OF A MOTOR VEHICLE 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 At-Fault Party

_____

_____ _____
At-Fault Party's Insurance Company At-Fault Party's Insurance Company's Address

Adjuster's Name _____ **Adjuster's Telephone Number** _____

Claim No. _____

Do you have vehicle insurance? Yes ___ **No** ___ ***If No, attach a copy of police report.**
Is there personal injury protection (PIP) or Med Pay under your vehicle insurance? Yes ___ **No** ___ Please attach photocopy of the insurance policy declaration page that states the monetary amount of coverage relating to this accident.
Name of your Insurance Company_____

Insurance Company's Address_____

Adjuster's Name _____ **Adjuster's Telephone Number** _____ **Claim No.** _____

Name of other family member(s) injured _____
Name and address of owner of vehicle in which patient was traveling: _____
Insurance Co., Claim No., Adjuster's Name and Phone No. for vehicle in above.
_____
_____
_____

Did 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: (If applicable)
Was the condition connected with employment? Yes ___ **No** ___
If Yes, please specify dates of the condition _____ **Claim No.** _____
Worker's 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 (Washington)? Yes_____ **No**_____

OTHER ACCIDENT OR INJURY: (If applicable)
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** ___
If Yes, give name of insurance company. _____ **Adjuster's Name** _____ **Claim No.** _____
Address: _____ **Phone No.** _____

SUBSCRIBER'S STATEMENT:
"I understand that if I, or any of my covered dependents, have been in an accident or have been injured by another party, or have a 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. As a condition of any payments by Regence BlueCross BlueShield of Oregon I and/or my covered dependent agree to cooperate with Regence BlueCross BlueShield of Oregon in its efforts to recover the benefits from the responsible party or the responsible party's insurer. If Regence BlueCross BlueShield of Oregon does not or chooses not to recover the benefits from the responsible party or the responsible party's insurer, I agree to reimburse Regence BlueCross BlueShield of Oregon the amount of benefits paid as stated in my health benefit plan, subject to applicable law.

I understand that the Regence BlueCross BlueShield of Oregon and anyone acting on its behalf is permitted by law to release information about any accident, injury, or work-related condition described on this form and the benefits and medical service I or my covered dependents received in connection with that accident, injury, or work-related condition to any potentially responsible party and the potentially responsible party's insurer.

I authorize my insurance company to release any information concerning my coverage to Regence BlueCross BlueShield of Oregon

I also authorize Regence BlueCross BlueShield of Oregon to review any workers' compensation claims files pertaining to me or any of my covered dependents so that Regence BlueCross BlueShield of Oregon can determine whether workers' compensation coverage is available for any potential work-related condition.

I certify that the information on this form is true and accurate to the best of my knowledge."

Subscriber Signature _____ Date _____ ID Number

_____ _____
Address Home Phone

_____ _____
Work Phone

Injured Dependent/Guardian Signature _____ Date _____ Relationship