

INCIDENT QUESTIONNAIRE - GENERAL INSTRUCTIONS FOR PROVIDERS

The Premera Blue Cross Incident Questionnaire (IQ) is required if the patient's treatment or condition requires investigation for other party liability, such as auto/work accident, or the diagnosis is one that requires a form. Assisting the member with the completion and submission of an IQ, following the guidelines below, will expedite the processing of the claims awaiting the return of the form.

If the cause of the injury is not related to an auto or work accident, the member can call our Customer Service Department and describe how the accident, injury or illness occurred. An IQ may still be required even if the condition did not result from a work or auto accident.

(The member can reference the Customer Service phone number on the back of his/her identification card.)

Follow these steps for the completion and submission of the IQ form:

1. Provider completes each line of the required information, located in the upper right-hand corner of the form. If information is missing, we may not be able to retain the IQ on file. *Please do not affix a sticker with patient information in lieu of completing the required fields.*
2. Include the ICD-9 Code(s) in the upper right-hand corner of the form. Diagnosis must match claim submission.
3. Ask the patient to legibly print and complete sections A-F and sign the form.
4. Ask the patient to provide a description in Section A of how the injury occurred if not related to an accident.
5. Submit completed IQ forms **separately** from claims.
6. Please **fax** this completed form to 425-918-5355 or **mail** to:

Premera Blue Cross
PO Box 327, Mail Stop 227
Seattle, WA 98111-0327

Note: The member has 45 days to complete, sign and return the IQ form if not completed during the office visit. Failure to return the completed form within the required time period will result in denial of the claim(s).

Guidelines to reduce the chances of the IQ not being filed for the relevant claims:

- Submit forms for only Premera patients (this excludes non-Premera BlueCard members).
- Do not customize or alter the form.
- Since this form will be updated periodically, do not print a large supply or it may become outdated.

Failure to follow these instructions may result in the IQ not being on file for relevant claims.

Patient name and address:

Today's date _____
Patient name _____
Patient date of birth _____
Member ID number _____
Group number _____
Provider name _____
Date of service _____
Diagnosis code (s) _____

Failure to return the questionnaire will result in claim(s) denial, and could also result in personal responsibility for charges. This claim cannot be processed until this incident questionnaire is fully completed, signed and returned.

A. General Information

▼ Was this claim related to an **incident/accident**?

No If you checked "No," please describe what happened and where it occurred (required):
 Gradual Onset
*Thank you for your information. Please skip to **section F** and sign & date this form.*

Yes Date incident/accident occurred: _____ If you checked "Yes," please continue to **section B**.


B. Incident/Accident Information

This claim is related to (please check the appropriate box):
 Work incident/accident or illness
 Motorized vehicle incident/accident, select one: Automobile Street Bike Dirt Bike Watercraft Snowmobile
 Other type of incident/accident → describe: _____

Describe how the incident/accident happened, including the location and state

State all parts of body and type of injuries involved (e.g., bruised left knee)

List any other family members involved in the incident/accident and their injuries:

 **Complete the appropriate sections below, and then skip to section F to sign & date form.**

C. Complete if you checked "WORK INCIDENT/ACCIDENT OR ILLNESS" in section B


Are you self-employed? No Yes Are you an owner or sole proprietor? No Yes

Do you have workers' compensation coverage? No Yes If yes, did you file a claim? No Yes

Workers' Compensation carrier and adjusters name:	Phone number	Address/City/State/ZIP
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What is the status of the Workers' Compensation claim?
 In review Denied liability*
 Accepted liability Appealing denial*
*** If a Workers' Compensation claim has been filed and denied, please include a copy of the denial letter.**

Patient's attorney name (if applicable)	Phone number	Address/City/State/ZIP
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 **After completing sections A, B & C, skip to section F to sign & date form.**

FOLD HERE →
.....
FOLD HERE →
.....

Complete if you checked "AUTOMOBILE OR MOTORCYCLE INCIDENT/ACCIDENT" in section BThe patient was a: Driver Passenger Bicyclist Pedestrian

Patient's auto insurance carrier's name Address/City/State/ZIP

Adjuster's name Phone number Policy number Claim number

Does this coverage include Personal Injury Protection (PIP) or other Medical Payment (MedPay) provisions? No Yes
Look for "Personal Injury Protection (PIP)" or "Medical Payments (MedPay)" on your policy's declarations page.**Do you have Uninsured/Underinsured (UM/UIM) coverage?** No Yes**IF PATIENT WAS** the passenger of the car, do they carry PIP or other MedPay provisions? No Yes▼ **IF PATIENT** did not own the vehicle, complete the following:

OWNER's name

OWNER's auto insurance carrier's name Policy number Claim number Does the owner's coverage include PIP or other MedPay provisions? No Yes▼ **IF ANOTHER VEHICLE WAS INVOLVED**, complete the following:

OTHER DRIVER'S auto insurance carrier's name Policy number Adjuster's name Adjuster's Phone number

OTHER DRIVER'S name Insurance carrier Address/City/State/ZIP Claim number

If no claim filed, do you plan to file a claim? No Yes → explain why not:▼ **ADDITIONAL INFORMATION****Has patient received a bodily injury settlement?** No Yes → date of settlement:With whom did patient settle? Patient's insurance company Another party's insurance company Patient's uninsured/under-insured policy

Patient's attorney name (if applicable) Address/City/State/ZIP Phone number

**After completing sections A, B & D, skip to section F to sign & date form.****E. Complete if you checked "OTHER TYPE OF INCIDENT/ACCIDENT" in section B**Did the incident/accident occur on property you own? No → complete the rest of this section Yes → skip to section F**Is there Medical Premise coverage on the property where the incident/accident occurred?** No YesIf yes, will you file a claim? No Yes**Have you filed an insurance claim with the at-fault party or do you anticipate pursuing a claim?**(Medical malpractice, slip & fall, product liability, product recall, home/business, assault, etc.) ? No Yes**If no, why?**

At-fault party's insurance carrier's name (if known) Insurance carrier's Address/City/State/ZIP Insurance carrier's phone number

At-fault party's name Policy number Claim number

Patient's attorney name Address/City/State/ZIP Phone number

F. PLEASE READ AND SIGN

Your health benefit plan (the Plan) includes a Subrogation provision. Subrogation means the Plan has the right to be reimbursed for benefits paid under your contract for medical services incurred as a result of an incident for which another party is liable or for which you have other coverage such as PIP or UM/UIM (uninsured or under-insured motorist). The Plan can recover from you and/or another party. Please contact us prior to any settlement.

As required by my contract, I agree to reimburse the Plan for the amount it has paid if any recovery is made from the party that is liable or from my other coverage. I also agree that any property/casualty or automobile insurer or Workers' Compensation carrier or governmental agency may release any personal health information about me related to this accident to Calypso Healthcare Solutions, an independent company responsible for providing subrogation services to Premera Blue Cross. This authorization is valid during the subrogation process.

Please note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Patient or Subscriber signature Printed name Daytime phone number Date signed

X

Upon completion of this form, please fax or mail it back to us within 45 days of the requested date.