Regence
Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association
1800 Ninth Avenue
PO Box 21267
Seattle, Washington 98111-3267
1 (800) 458-3523

Uniform Medical Plan

Subject: Please Complete and Return Enclosed Incident Report

Dear Member:

We have recently received claims for health care services that appear to be related to an accident, injury, work-related condition, or possibly caused by another person. We believe this could be the case based on the codes used by your doctor, caregiver, or hospital to bill us for the services provided. These codes however do not tell us how or why you needed this treatment.

On the back of this letter you will find a list entitled “Common Situations in which Another Party may be Responsible for Your Medical Claims”. This list explains the most common type of injuries caused by another (called “other-party” injuries).

The “Incident Report” that is enclosed with this letter will help us determine if your injuries are “other-party” related. Please complete, sign and promptly return (self addressed envelope included) the Incident Report to us. Complete information is essential and very much appreciated.

It is important for you to know that if we do not receive the completed and signed Incident Report within 45 days, all claims related to this incident will be denied until the Incident Report is received. Please be aware that if claims are denied due to tardiness in returning your completed Incident Report, charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

As your health plan, we are committed to providing you with the benefits of your coverage. Your assistance in promptly completing and returning your Incident Report helps control the cost of health care coverage for everyone.

If you have any questions, please call our Customer Service Department at 1 (888) 849-3681. TTY users should call 711. We can be reached between the hours of 7 a.m. to 5 p.m., Monday through Friday, Pacific Time. You can also contact us via Live Help on myRegence.com.

Thank you for your timely response, and best wishes for a full and speedy recovery.

Enclosure: IR
Envelope

Common Situations in which Another Party may be Responsible for Your Medical Claims

Automobile Injury or Accidents

If you were involved in an automobile accident (as a driver, a passenger, a pedestrian, or as a bicycle rider) and you or any other person involved in the accident has automobile coverage that includes Personal Injury Protection (PIP) coverage or Medical Payment (Med-Pay) coverage, then the PIP or Med-Pay insurer will have initial coverage responsibility. Accordingly, please notify your auto insurance carrier and Regence BlueShield (Regence) so that we are both aware of the accident.

When the limits of the medical benefits covered by your auto insurance have been paid, your auto carrier will provide you with an "exhaust letter" and an itemization of payment(s) made. These documents will show which claims your automobile carrier paid and which claims your health plan may still need to pay.

Please send us copies of these documents promptly after you receive them.

- In some states, injuries getting into, out of, working on, loading, unloading and while occupying the vehicle, are covered by your auto insurance. Be sure to check your policy, or, if you're still in doubt, check with your agent or auto insurance carrier.
- If you do **not** have medical benefits on your auto insurance, please send a copy of your Policy Declarations Page (it's usually the first page of the policy and summarizes your coverage) to us to help us verify and accurately handle your claims.

Work-Related Accidents/Illness/Condition

If you have an injury or a condition/illness that is work-related, such as a hernia, carpal tunnel syndrome, chemical exposure, strains, sprains, etc., a claim needs to be submitted to your employer's workers' compensation carrier so that you can benefit from the coverage of the workers' compensation insurance policy.

After filing your worker's compensation claim, please provide Regence with the status of your claim by providing the claim number and the date the injury occurred or the condition or illness began. In addition, please provide us with:

- A copy of the workers' compensation condition acceptance letter; and
- The accepted condition or injury that the workers' compensation carrier has allowed; or
- If your claim is denied by the workers' compensation carrier, please send a copy of the denial and a note telling us whether you are going to appeal the denial.

If a workers' compensation claim has been accepted and then closed but you have additional claims attributable to the work-related injury, illness, or condition, you have the right to re-open your claim with the workers' compensation carrier so long as your treatment is still related to that injury, illness, or condition.

No-Fault Premise Medical

If you have been injured on someone else's property, the property owner often carries No-Fault Premise Medical insurance, generally called "Guest Medical" coverage that would cover your medical expenses up to a specific dollar limit (usually $1,000 to $5,000) even if your injury was incurred through no fault of the property owner's. You should check with the property owner if they have this coverage and let us know if the property owner is going to file a claim that would cover your medical expenses.

Today's Date: (mm/dd/yyyy) _____
ID Number: _____
Claim Number: _____
Provider Name: _____
Date of Service: (mm/dd/yyyy) _____
Client Letter ID: _____

INCIDENT REPORT

Please complete this Incident Report and return it in the enclosed envelope within 45 days of receipt. If we do not receive your complete and signed Incident Report within forty-five days, all claims related to this incident will be denied until the Incident Report is received. Please be aware that if claims are denied due to tardiness in returning your completed Incident Report, charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

Complete information is essential and very much appreciated. When additional information is required, claims cannot be processed. It will take up to 15 days after we receive all necessary information before claims can be processed. To avoid these delays, carefully and completely provide all requested information.

General Information
Briefly explain why you sought treatment. Please identify the specific body area(s) affected by this injury, if applicable. Date of Injury or onset of illness: _____ (mm/dd/yyyy) Explanation: (How did the injury occur? What was injured? Where did the event occur?) _____
Was the service received for the injury described above related to an incident that occurred: ☐ At work or on the job; or ☐ Due to an auto accident or auto-related injury; or ☐ Due to an Other Vehicle Accident (motorcycle, scooter, snowmobile, boat, etc. accident); or ☐ Caused by another party; or ☐ Caused by something/someone at a business or residence other than your own home?
The service received from the injury described above: ☐ Was not incurred at work or on the job; or ☐ Was not caused by another party or incurred as the result of an accident; or ☐ No other person was involved. Please explain: _____

If the injuries you sustained were not related to an accident or incurred at work or on the job, please skip to the bottom of this form and sign, date and return it to us.

Otherwise, please continue on and complete the applicable section(s) below, then sign, date and return the form.

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

Attorney's Name: _____ Phone No. _____ (xxx) xxx-xxxx

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

HAVE YOU BEEN OFFERED A SETTLEMENT? ☐ Yes ☐ No

Have you accepted a settlement? ☐ Yes ☐ No

If Yes, date of settlement: _____ (mm/dd/yyyy) Amount of settlement: _____

Please include a copy of your settlement documents

WAS THE TREATMENT A RESULT OF AN AUTO/OTHER TYPE OF VEHICLE INJURY/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 the At-Fault Party _____

At-Fault Party's Insurance Company _____

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

Adjuster's Name _____ Adjuster's Telephone Number _____ (xxx) xxx-xxxx

Claim No. _____ Adjuster E-mail Address _____ Email address

Do you have vehicle insurance? ☐ Yes ☐ No *If No, attach a copy of police report.

Is there Personal Injury Protection (PIP) or Medical Payments (Med-Pay) under your vehicle insurance?

☐ Yes ☐ No

Please attach a photocopy of your insurance policy declaration page that shows what types of coverage you have (in particular, whether your policy provides PIP or Med-Pay coverage) and the monetary amount of your coverage.

Name of your Insurance Company _____

Insurance Company's Address _____

Adjuster's Name _____ Adjuster's Telephone Number _____ (xxx) xxx-xxxx

Claim No. _____ Adjuster E-mail Address _____ Email address

Name of other family member(s) covered on your health plan that were injured: _____

_____

If accident was not in your own vehicle, 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 which patient was traveling: _____

_____

Did this vehicle 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: Was the service you received necessitated by an injury, condition, or illness caused or received at work or on the job? ☐ Yes ☐ No

If Yes, please tell us what happened: _____

_____

When (or over what period of time) did you incur your injury or illness:_____

_____

Have you filed a claim with Workers' Compensation? ☐ Yes ☐ No

If yes, please provide: Claim Number _____

Worker's Compensation Carrier Name, Address: _____

_____

Adjuster's Name _____ Adjuster's Telephone Number (xxx) xxx-xxxx

*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:

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

Do you intend to file a claim? ☐ Yes ☐ No

If Yes, please provide the name of the insurance company. _____

Adjuster's Name _____ Claim No. _____

Address. _____ Phone No. (xxx) xxx-xxxx

SUBSCRIBER'S STATEMENTS

I understand that if I, or any of my covered dependents ("Subscriber") 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. The Subscriber further understands that, as a condition of coverage, the health benefit plan requires the Subscriber to cooperate with Regence in its efforts to recover the cost of benefits it has provided from the responsible party or the responsible party's insurer, and that if the Subscriber does not cooperate in full accordance with the health benefit plan, that Regence may pursue reimbursement from the responsible party, or the responsible party's insurer, or from the Subscriber in accordance with the health benefit plan and applicable law.

The Subscriber understands that Regence and anyone acting on its behalf is permitted by law to release information about any accident, injury, or work-related condition described on this Incident Report and the benefits and medical service the Subscriber received in connection with that accident, injury, or work-related condition to any potentially responsible party and the potentially responsible parties' insurer.

The Subscriber authorizes the insurance company(ies) listed above to release any information concerning the Subscriber's coverage to Regence. The Subscriber further authorizes Regence to review the Subscriber's workers' compensation claims files pertaining to this Incident Report so that Regence can determine whether workers' compensation coverage is available for any potential work-related condition.

The Subscriber understands that it is a crime to knowingly provide false, misleading, or incomplete information to Regence with the intent of defrauding the company, and that the penalties for committing fraud include imprisonment, fines and the denial of insurance benefits. Moreover, Regence will have the right to pursue its legal rights, including the collection of claims payments and any other damages.

The Subscriber accordingly declares that the above information is true, correct and complete.

DATED AND SIGNED on the _____ day of _____, 20_____.

(xxx) xxx-xxxx	(xxx) xxx-xxxx
Home Phone	Work Phone
(xxx) xxx-xxxx	Email address
Cell Phone	E-Mail Address

	(mm/dd/yyyy)	
Subscriber's Signature	Date	ID Number
	(mm/dd/yyyy)	
Injured Dependent/Guardian Signature	Date	Relationship

We may need to contact you further to clarify your answers or obtain additional information. Please include available times if there are time restrictions regarding when we should contact you. Also, please include your email address if it's okay to contact you in that manner.

Additional information/clarification: _____