



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 \_\_\_ Auto \_\_\_ Motorcycle \_\_\_ Caused by another party \_\_\_ Other \_\_\_ No accident on the job

*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