Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

1800 Ninth Avenue
PO Box 91015
Seattle, WA 98111-9115

Uniform Medical Plan

Today's Date:
ID Number:
Patient:
Claim Number:
Provider Name:
Date of Service:
Client Letter ID:
Group ID:
Group Name: **Washington State Health Care Authority**

INCIDENT REPORT

Please complete this Incident Report (IR) and return it in the enclosed envelope.

You can assure that all claims are processed promptly by returning the information as quickly as possible. If we do not receive your complete and signed IR, all claims related to this incident will be closed until the IR is received.

Charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

1. Was the service received for the injury described above related to an incident that occurred:

Please check the appropriate box below:

- ☐ At work or on the job
- ☐ Due to an auto accident or auto-related injury
- ☐ Due to an accident with a different type of vehicle (motorcycle, scooter, snowmobile, accident)
- ☐ Caused by something/someone at a business or residence other than your own home
- ☐ Illness condition not caused by an injury or accident. Please describe your reason for seeking treatment:

  _____

  _____

  _____

- ☐ Other

2. If you have checked any of the boxes above, please continue and complete all applicablesection(s) below, then sign, date and return the entire form.

Questions	Your response needed
Date of injury or onset of illness or condition?	
List body areas affected by this injury, illness or condition.	
What City/State & Location (i.e. residence, school, etc,) did the event occur?	
How did the injury, illness or condition occur?	

3. Do you intend to seek recovery for damages resulting from the injury, illness, or condition?

Yes ___ No ___

If your case has settled, please include a copy of your settlement documents.

Have you been offered a settlement? Yes _____ No _____

Have you accepted a settlement? Yes _____ No _____

If Yes, date of settlement: _____ Amount of settlement: _____

Have you hired an attorney? Yes _____ No _____

Please forward this form to your attorney to complete if you do not have all information needed to be complete the below areas.

Attorney's name: _____ Fax Number: _____

Phone Number: _____

Attorney's address:

_____

_____

4. Was your treatment the result of an auto or other type of vehicle accident?

Yes ____ (please give details) **No ____**

You were a: Driver _____ Passenger _____ Pedestrian _____ Other _____

Were there other family member(s) covered on your health plan who were injured?
Yes _____ No _____ If **yes**, due to privacy protection, please contact us directly so we may obtain information pertaining to other family members.

The vehicle was a: Car ___ Motorcycle ___ ATV ___ Snowmobile ____ Other ____

Was there more than one vehicle involved? Yes ____ No ____

Name of the at-fault party _____

At-fault party's insurance company _____ Claim no. _____

At-fault party's insurance company's address _____

Adjuster's name _____ Adjuster's telephone number _____

Adjuster's fax number _____ Adjuster E-mail Address _____

Do you have vehicle insurance? Yes ___ No ___

- Does your vehicle insurance include Personal Injury Protection (PIP) or Medical Payments (Med-Pay)? **Yes ___ No ___ If PIP/Med-Pay exhausted, please provide a copy of auto insurance payment ledger.**
- 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 _____

Claim no. _____
Insurance company's address _____
Adjuster's name _____ Adjuster's telephone number _____
Adjuster e-mail address _____ Adjuster's fax number _____

If accident was **not in** your own vehicle, name of the owner of vehicle in which patient was occupying:

_____

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)

Insurance company _____ Claim no. _____

Adjuster's name _____ Adjuster's telephone number _____

Adjuster's e-mail address _____ Adjuster's fax number _____

5. Was your treatment the result of injury, condition, or illness caused (received) at work or on the job?

Yes _____ (please give details) No _____

Are you self-employed? Yes _____ No _____

If Yes, do you carry a policy that covers work related injuries for yourself? Yes ____ No _____

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 no. _____

Worker's compensation carrier name, address:

_____

_____

Adjuster's name: _____ Adjuster's phone number _____

Has your claim been denied? Yes ____ No _____ **If yes, please include a copy of your denial.**

Do you plan to appeal this decision? Yes _____ No _____

Has your claim been closed? Yes _____ No _____ If yes, what date was it closed? _____

Have you filed to re-open this claim? Yes _____ No _____

_____

6. Other type of accident, injury or illness? **Yes _____** **No _____**

If yes (please give details)

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 _____

Was the accident or injury the result of negligence by another party? Yes _____ No _____

Have you filed (or intend to file) a claim? Yes _____ No _____

Please provide the name of the insurance company:

_____

_____

Claim no. _____ Adjuster's name:_____

Address:

_____

_____

Adjuster's e-mail address _____ Phone no._____

SUBSCRIBER'S STATEMENTS

I (the subscriber, covered person, and/or personal representative thereof), understand that if I or any covered dependents have been injured 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 any covered dependents, subject to the terms, limitations, and exclusions of the plan.

I further understand that, as a condition of coverage, the health benefit plan requires me to cooperate with Regence in its efforts to recover the cost of benefits it has provided from any responsible party or any responsible party's insurer, and that if I do not cooperate in full accordance with the health benefit plan, that Regence may pursue reimbursement from any responsible party, or any responsible party's insurer, or from me in accordance with the health benefit plan and applicable law.

I understand 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 I received in connection with that accident, injury, or work-related condition to any potentially responsible party and the potentially responsible parties' insurer.

I authorize the insurance company(ies) listed above to release any information concerning my coverage to Regence. I further authorize Regence to review my 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.

I understand 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.

I accordingly declare that the above information is true, correct, and complete.

Subscriber's Signature	Date	ID Number
Dependent/Guardian/Representative Signature	Date	Relationship

Home Phone	Work Phone
Cell Phone	Email Address

We may need to contact you to clarify your answers or get more information. Please include available times when we should contact you.