

INCIDENT QUESTIONNAIRE - GENERAL INSTRUCTIONS FOR PROVIDERS

The Premera Blue Cross Incident Questionnaire (IQ) Form 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 claims awaiting return of the form.

Visit the Washington Health Care Forum web site at www.wahealthcareforum.org to review a list of diagnostic codes that may cause a claim to suspend for investigation of other party liability.

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.

(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 1 – 8 and sign the form.
4. Ask the patient to provide a description in Section 1 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 425-918-5878 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 may result in denial of the claim(s).

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

- Submit forms only for Premera patients (this excludes non-Premera BlueCard members).
- Do not complete sections 1 – 8 for the patient.
- We do not accept N/A responses in sections 1 – 8.
- Do not submit an incomplete form.
- 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- Since this form will be updated periodically, do not print a large supply or it may become outdated.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.

Subscriber ID#: _____

Patient: _____

Patient Date of Birth: ____ / ____ / ____

Group #: _____

Date(s) of Service: _____

Provider: _____

Diagnosis Code(s): _____

Dear Subscriber:

The above-listed service indicates that you may have been involved in an accident or have sustained an injury. In order to proceed with the processing of your health care claims, we need your help. Please return this form within 45 days with complete answers to all questions **ON BOTH SIDES**. THIS CLAIM CANNOT BE PROCESSED UNTIL THIS INCIDENT QUESTIONNAIRE IS **FULLY COMPLETED, SIGNED AND RETURNED**. When we receive the completed questionnaire, we'll process your claim within 15 days. **FAILURE TO RETURN THE COMPLETED QUESTIONNAIRE WITHIN 45 DAYS WILL RESULT IN DENIAL OF THE CLAIM(S)**. Thank you for your prompt attention. We appreciate your assistance in providing this information so that we may complete the processing of your claim(s). Please return this form to the address listed above.

1	If this injury or condition was not the result of an accident, please describe how you sustained the condition: _____
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2	Date of injury or onset of condition: _____ Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Type of injury/condition sustained: _____ _____ Names of any other family members injured: _____ Address or location where injury/onset of condition occurred: _____ _____ Do you own this property? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, go to # 3. If Yes, skip to # 4.</i>
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3	Did the injury or onset occur on another party's property? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, skip to # 4.</i> Is this property a rented home or apartment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, skip to # 4. If No, please provide:</i> Location Name: _____ <input type="checkbox"/> School <input type="checkbox"/> Homeowner's Residence <input type="checkbox"/> Business <input type="checkbox"/> Other Owner/Representative: _____ Phone: _____ Address: _____ Location's Insurance Company Name: _____ Policy #: _____ Adjuster or Agent Name: _____ Phone: _____ Claim #: _____
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4	Was the injury/condition sustained while performing work required for employment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, skip to # 5</i> Is the injured person covered by Workers Compensation Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain: _____ Are you self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have 24-hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a Workers Compensation claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please provide Claim #</i> _____ Was a Workers Comp. claim denied? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please attach a copy of the denial. Will you appeal?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
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5	Did the injury/onset occur in, on or near a snowmobile, boat or personal watercraft? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If No, Skip to # 6.</i> Description of motorized craft: _____ I was a: <input type="checkbox"/> Driver/Pilot <input type="checkbox"/> Passenger <input type="checkbox"/> Bystander Does the owner of this motorized craft have medical payment coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes, please provide:</i> _____
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5 (continued)
(This information will appear on your insurance premium bill or declarations page.)
 Owner's Name: _____ Phone: _____ Address: _____
 Insurance Company Name: _____ Policy #: _____
 Address: _____
 Adjuster or Agent Name: _____ Phone: _____ Claim # _____

6 **Did the injury occur in, on or near a motor vehicle?** Yes No *If No, skip to #7. Please provide:*
 I was a: Driver Passenger Pedestrian Bicyclist
 * If passenger, did the car you were in carry Personal Injury Protection or Medical Payments provision? Yes No
Required: YOUR Auto Insurance Company Name: _____ Policy #: _____
 Address: _____
 Adjuster or Agent Name: _____ Phone: _____ Claim # _____
Does your automobile coverage include Personal Injury Protection or other Medical Payment provisions? Yes No
("Personal Injury Protection" or "PIP" or "Medical Payments" will appear on your wallet card, bill or your policy's declarations page.)

6a **If you were the driver, did you own the vehicle?** Yes No *Please provide:*
 OWNER'S Name: _____ Phone: _____ Address: _____

 OWNER'S Auto Insurance Company Name: _____ Policy #: _____
 Address: _____
 Adjuster or Agent Name: _____ Phone: _____ Claim # _____
Does your automobile coverage include Personal Injury Protection or other Medical Payment provisions? Yes No
("Personal Injury Protection" or "PIP" or "Medical Payments" will appear on your wallet card, bill or your policy's declarations page.)

6b **Was another vehicle involved?** Yes No *Please provide:*
 OTHER DRIVER'S Name: _____ Phone: _____ Address: _____

 OTHER DRIVER'S Auto Insurance Company Name: _____ Policy #: _____
 Address: _____
 Adjuster or Agent Name: _____ Phone: _____ Claim # _____

6c **Did the police investigate?** Yes No *If Yes, was anyone cited?* _____ **Case #:** _____
Have you received a settlement? Yes No *If Yes, what was the date of the settlement?* _____

7 **Will you pursue a liability claim against another party?** (I.e., Auto, Medical Malpractice, Slip and Fall, Product Liability, Product recall, Home/Business, etc.) Yes No *If Yes, describe:* _____

8 **Have you retained an attorney regarding this injury/incident?** Yes No *Please provide:*
 Attorney's Name: _____ Phone: _____
 Address: _____

***** PLEASE READ AND SIGN *****

Your health benefit plan (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 recovery is made from the party that is liable or from another first party payer. I understand that any person who knowingly (and with intent to injure, defraud or deceive an insurance company) files a claim containing false, incomplete and/or misleading information may be prosecuted under state law.

Signature of Subscriber (required)

Signature of Injured Party

Phone Number (day)

Phone Number (evening)

Date