Regence BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 91015
Seattle, Washington 98111-9115

MEDICAL SERVICE INQUIRY

MEMBER I.D. NUMBER
CLAIM NUMBER
PATIENT NAME
DATE(S) OF SERVICE
PROVIDER OF SERVICE

Dear Member:

We have recently received claims for the medical care incurred by the above-named patient for what appears to be an injury or accident. Please use this form to describe what happened to cause the above-named patient to seek medical care on the above date of service. If this is an injury or a job-related condition, please fill out Section 2 or 3. If this is an automobile accident, please complete Section 4.

Please complete this form and return it within 45 days of receipt. When additional information is required and claims are held for return of that information, we may extend the overall time taken to process the claim to include an additional 15 days. Without this additional information, we will be unable to process this claim and related claims. If you have any additional questions, please call Customer Service at 1 (800) 422-7713.

1. GENERAL INFORMATION

Briefly describe what caused the patient to seek medical care on the above date of service.

2. INJURY

What was the date of the injury?____________________________

Did the accident occur on someone else's property? ☐ Yes ☐ No

Please provide the name and address of the legal owner of the property where the injury or accident occurred:

Name of Owner	Telephone Number
Address (Street, City, State, Zip)	

Does the owner of the property have insurance to cover medical expenses? ☐ Yes ☐ No

If yes, please provide the name and address of that insurance company:

Name of Insurance Carrier	Telephone Number
Address (Street, City, State, Zip)	
Name of Claim Adjustor	Claim Number

Have you submitted, or do you intend to submit, a claim to that insurance company? ☐ Yes ☐ No

3. ON-THE-JOB INJURY OR ILLNESS

Did this condition or injury occur on the job as a result of your employment? ☐ Yes ☐ No

If yes, did the patient apply for workers' compensation benefits? ☐ Yes ☐ No

Is the patient's employer self-insured or covered through the Department of Labor & Industries?

☐ Self-insured
☐ Covered through the Department of Labor & Industries   Claim Number________________________

If the patient has not applied for workers' compensation benefits, please explain why not:

____

____

4. VEHICLE ACCIDENT

Was this a ☐ Car ☐ Motorcycle ☐ Other Please specify: ____________________

Was the patient ☐ Driver ☐ Passenger ☐ Pedestrian

Please provide the name of the registered owner of the vehicle in which the patient was driving/riding:

Name

Who is responsible for the accident?

Name	Telephone Number	Drivers License Number
Address (Street, City, State, ZIP)		

What is the responsible party's insurance company?

Company Name	Telephone Number	Name of Adjuster
Address		Claim Number

Were any other members of your family injured in this accident? ☐ Yes ☐ No If yes, please specify first names:

____

Do you have vehicle insurance? ☐ Yes ☐ No If yes, what is your insurance company:

Company Name	Telephone Number	Name of Adjuster
Address		Claim Number

Does your policy contain medical provisions? ☐ Yes ☐ No

Please attach a copy of the page of the insurance policy that states the monetary amounts of the coverage relating to this injury.

Do you intend to seek recovery of damages from the responsible party? ☐ Yes ☐ No

Have you been offered a settlement? ☐ Yes ☐ No Have you accepted? ☐ Yes ☐ No If yes, settlement date: ___/___/___

If you have consulted an attorney for your injury, you must complete section 5.

5. ATTORNEY INFORMATION

Have you retained an attorney regarding legal protection for this injury? ☐ Yes ☐ No

If yes, please provide the name and address:

Name	Telephone Number
Address (Street, City, State, ZIP)	

PLEASE READ AND SIGN:

Your Boeing Plan contract includes a Subrogation provision. "Subrogation" means that if a subscriber or dependent is injured by another party who is legally liable for the medical bills, upon request by the subscriber, the Boeing Plan will pay regular contract benefits. In exchange for this, the subscriber transfers to the Boeing Plan his or her right to recover from the third party any amounts paid in benefits to the injured person.

I understand that if I or one of my dependents has been injured by another party, the benefits of my contract will be available to the injured person, subject to the exclusions and limitations of the contract. I agree to cooperate with the Boeing Plan in its subrogation rights as explained in my benefits brochure and master contract. I agree to reimburse the Boeing Plan for the amount it has paid if recovery is made from the party that is liable. I certify that the information on this form is true and accurate to the best of my knowledge.

I hereby authorize the Boeing Plan and anyone acting on behalf of it, including Regence BlueShield, to release any information about my accident and the benefits and medical services I received in connection with my accident to any person who may be liable to me or the Boeing Plan, and to the insurance company of any such person or to any insurance company that provides coverage for injuries related to this accident. I further authorize my insurance company to release any information concerning my coverage to the Boeing Plan and Regence BlueShield.

Subscriber's Signature ______________________________ **Date** ____________

Member ID Number ____________________ Home Telephone ____________ Work Telephone ____________

Address ______________________________