Subrogation / Workers' Compensation
I-20 at Alpine Road
Columbia, SC 29219-0001
1-800-288-2227, extension 43060
Fax: 1-803-865-0654

BlueCross BlueShield
Of South Carolina

An independent licensee of the Blue Cross and Blue Shield Association

ACCIDENT QUESTIONNAIRE

Subscriber: ____________________
Address: ____________________
Address: ____________________

Patient: ____________________
Identification No.: ____________________
Provider: ____________________
Date of Service: ____________________
Group Number: ____________________
Claim Number: ____________________
Claim Amount: ____________________

Dear Member:

Our review process indicates this patient may have received healthcare services related to an accident. So we may evaluate our responsibility, please complete, sign and return this form within five days of receipt. If we do not receive this information, we may have to deny your claims. **If you have previously completed a form for this accident, please check here _____ and update.**

Was the injury or illness: **Auto/Motorcycle Accident**_____ **Work Related**_____ **Other Accident**_____ **No Accident** _____
Date of the injury or illness: ____________________ City/County and State of Injury: ____________________
Describe the injury or illness and how it happened: ____________________
____
Names of other family members injured: ____________________

If you checked "Auto/Motorcycle Accident" or "Other Accident," please answer the following:

Did another person cause this accident? YES / NO
If yes, name and address of person causing injury: ____________________
Insurance Company of person causing injury: ____________________ Policy/Claim # : ____________________
Address and Phone #: ____________________ Adjuster's Name: ____________________
If auto or motorcycle related, was the patient wearing a seatbelt? YES / NO a helmet? YES / NO
If auto or motorcycle related, was the patient the driver ________ or a passenger ________ ?
Auto Insurance Company of Patient: ____________________ Policy/Claim #: ____________________
Address and Phone #: ____________________ Adjuster's Name: ____________________

If you checked "Work Related," please answer the following:

Name and address of patient's employer at the time of injury: ____________________
Have you filed a Workers' Compensation claim? YES / NO
If yes, name of Workers' Compensation carrier: ____________________
Policy/Claim # : ____________________ Adjuster's Name: ____________________
Address and Phone # ____________________
Has the employer or the workers' compensation carrier accepted or denied liability? ACCEPTED / DENIED

Name, address, and telephone number of your attorney (if applicable): ____________________
____

I agree that the above information is correct, and I will not settle a claim before contacting the Subrogation / Workers' Compensation Department of BlueCross BlueShield of South Carolina.

____

Signature Date Telephone Number

BlueCross BlueShield of South Carolina

Visit our Web site at:
www.SouthCarolinaBlues.com

OTHER HEALTH/DENTAL COVERAGE QUESTIONNAIRE

Your contract contains a Coordination of Benefits (COB) provision to ensure we provide correct benefits on claims for members with more than one health/dental coverage plan. We need information about possible other health/dental coverage, including Medicare, to process your claims correctly.

______________________ ID Number: ______________________
____
______________________ Date: ______________________

1. Do you or any dependents have any other group health, dental or Medicare coverage? ☐ No ☐ Yes

IF NO, PLEASE SIGN, DATE AND RETURN THIS FORM OR CALL US AT OUR COB HOTLINE (1-800-931-3401) AND WE WILL PROCESS THIS INFORMATION IMMEDIATELY. IF YOU ANSWERED YES, PLEASE PROCEED TO QUESTION #2.

Your Signature: ______________________ Date: ______________

2. Please list the family members covered by the other policy and the type of coverage you have.

______________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare
______________	☐ Medical	☐ Hospital	☐ Drug	☐ Dental	☐ Medicare

For additional family members, attach sheet with information.
*** If you checked Medicare, answer number 7 on page 2.**

3. Name of other policyholder. ______________________

Other policyholder's date of birth: ______________ Relationship to you: ______________

4. Employer name if coverage is provided through an employer: ______________________

5. Name of other insurance company and effective date of policy. ______________ Effective Date ______________

If policy is now terminated, please give termination date. ______________ ID# ______________

6. If there is a divorce or separation, please list who is responsible for the healthcare expenses. ______________

If there is a copy of a divorce decree, please forward a copy to us.

If there is not a court decree, who has custody of the children? ______________________