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

South Carolina

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 Blue Cross and Blue Shield.

_____
Signature Date Telephone Number

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Visit our website 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 (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 a separate sheet with the information.
* **If you checked Medicare, answer question #7 on page 2.**

3. Name of Other Policyholder: _____

Other Policyholder's Date of Birth: _____ Relationship to You: _____

4. Employer's 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. The Other Insurance Company's Address: _____
7. The Payor ID for the Other Insurance Company (if known): _____
8. If there is a divorce or separation, please list who is responsible for the health care 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? _____

* * * * * SECTION PERTAINS TO MEDICARE COVERAGE ONLY * * * * *

9. Are you actively working? ☐ Yes ☐ No Start Date: _____ **Last Day of** Active Employment: _____

10. Are you or any family members covered by Medicare? ☐ No ☐ Yes
If No, please sign and date below. If Yes, please complete the information below.

- Name: _____ Date of Birth: _____

Medicare Number: _____ Part A Effective Date: _____

Part B Effective Date: _____

Reason for Medicare (check one):

☐ Age
☐ Disability
☐ ESRD Date of First Dialysis: _____

- Name: _____ Date of Birth: _____

Medicare Number: _____ Part A Effective Date: _____

Part B Effective Date: _____

Reason for Medicare (check one):

☐ Age
☐ Disability
☐ ESRD Date of First Dialysis: _____

Your Signature: _____ **Date:** _____

Please mail or fax this form to the correct plan:

- **State Health Plan ("ZCS" and "ZCK" Prefix)**

State Health Plan: AX-B10
ATTN: COB
P.O. Box 100605, Columbia, SC 29260-0605
Fax: 803-264-4204

- **Small Group and Individual ("ZCY" Prefix)**

Group and Individual: AX-F25
ATTN: COB
P.O. Box 100246, Columbia, SC 29202-3246
Fax: 803-264-0172

- **Preferred Blue® and All Other BlueCross Plans (Include name of health plan.)**

BlueCross BlueShield of South Carolina
P.O. Box 100300
Columbia, SC 29202

Check your member ID card for Service Center location:
Piedmont (Greenville) Service Center: Fax: 803-264-9128
Columbia Service Center: Fax: 803-264-6572