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 Blue Shield Association.

Visit our website at:
www.SouthCarolinaBlues.com

OTHER HEALTH OR DENTAL COVERAGE QUESTIONNAIRE

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

Name: _____ ID Card Number: _____

Address: _____ Date: _____

_____

_____

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

If no, please sign, date and return this form or call us at 1-800-931-3401, and we will process this information immediately. If you answered yes, please proceed to the next question.

Signature: _____ Date: _____

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

Name: _____ ___ Medical ___ Hospital ___ Drug ___ Dental ___ Medicare
Name: _____ ___ Medical ___ Hospital ___ Drug ___ Dental ___ Medicare
Name: _____ ___ Medical ___ Hospital ___ Drug ___ Dental ___ Medicare

3. Name of other policyholder: _____
   Date of Birth: _____ Relationship: _____
4. Employer's Name (If coverage is provider through an employer): _____
5. Name of Other Insurance Company: _____ Effective Date: _____
   If policy is termed, termination date: _____ ID Number: _____
6. Other Insurance Company's Address: _____

   _____

   _____
7. Payor ID for Other Insurance Company (If known): _____
8. If divorce or separation, who is responsible for the health care expenses? _____
   If there is a copy of the divorce decree, please forward a copy to us.
   If there is no court decree, who has custody of the children? _____

******* THIS 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? ___ Yes ___ No

If yes, please complete the following information:

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: _____

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: _____

Signature: _____ Date: _____

Please mail of fax this form to the appropriate plan:

State Health Plan
Attn: COB
P.O. Box 100605, Columbia, SC 29260
Fax: 803-264-4204

Federal Employee Program
Attn: COB
P.O. Box 100603, Columbia, SC 29260
Fax: 803-736-8341

Small Group and Individual
Attn: COB
P.O. Box 100246, Columbia, SC 29202
Fax: 803-264-0172

Preferred Blue and All Other BlueCross Plans
Attn: COB
P.O. Box 100300, Columbia, SC 29202
Fax: 803-264-6572 (Columbia) or 803-264-9128 (Greenville)