

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



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

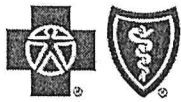
Name, address, and telephone number of your attorney (if applicable): _____

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 provided through an employer): _____

5. Name of Other Insurance Company: _____ Effective Date: _____

If policy is terminated, 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 or 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)