



BlueCrossBlueShield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

560 N. Park Avenue
P.O. Box 4309
Helena, MT 59604
(406) 444-8200

Customer Information Line:
1-800-447-7828

PLEASE COMPLETE, SIGN, AND RETURN THIS FORM WITHIN 5 DAYS

Subscriber ID:
Dependent No:
Patient:

Service Date:
Provider:
Claim Number:

Dear Member or Patient: We are sending you this questionnaire to help hold down the cost of your health care coverage. While we want to pay claims that are our responsibility, we investigate to determine whether other coverage, such as Workers' Compensation or liability insurance, may be responsible for them. When you accepted your health coverage, you agreed to release and provide any information we feel is necessary to determine whether such coverage applies. Please provide the information requested below so we can ensure that proper benefits are provided under your health coverage plan. Your claim cannot be processed until this form is completed and returned. Thank you for your assistance.

GENERAL INFORMATION (CHECK APPROPRIATE BOX):

Please complete sections A and C

If injury or illness occurred during employment, it is not necessary to complete section A. Please complete sections B and C only.

SECTION A. ACCIDENT / GENERAL LIABILITY / OTHER LIABILITY / OTHER

(Example: Motor vehicle, property, product, negligence)

- 1. Date of accident, injury, or condition:
2. Describe how the accident, injury, or condition occurred:
3. What body part(s) was/were affected?
4. Is another party liable for this accident, injury, or condition?
5. Has a court action been filed against the responsible party(ies)?
6. Please list names of any other family member(s) injured in this accident:
7. If this accident, injury, or condition is not motor vehicle related, please list the name of the party responsible for the accident or injury, and the name of their insurance company.

- 8. If motor vehicle related:
a. Is there medical coverage available through an automobile insurance policy?
b. If "Yes," how much? \$
c. Number of vehicles involved:
d. Was the patient a:
e. Driver's name and auto insurance company
9. Have you reported this accident to your own automobile or home insurance agency/company?
10. Have you hired an attorney to represent you as a result of this accident, injury, or condition? If "Yes":
Name:
Address:
Phone:

SECTION B. WORK RELATED

- 1. Date of accident, injury, or condition:

- 2. Describe how the accident, injury, or condition occurred:

- 3. What body part(s) was affected:

- 4. Has the employer been notified of this accident, injury, or condition?
 Yes No
- 5. Has a claim for benefits under Workers' Compensation or similar laws been filed?
 Yes No
- 6. Employer's name:

- 7. Employer's workers' compensation carrier:

SECTION C. SIGNATURE

I have answered these questions to the best of my knowledge.

Signature	Date	Relationship to Patient
Telephone Number (_____) _____ (_____) _____	(Home)	(Work)

We appreciate your help and assistance!

Please return this form within five days.

Mail or fax this form to:
Blue Cross Blue Shield of Montana
P.O. Box 5004
Great Falls, MT 59403-5004