

INCIDENT REPORT

GENERAL INFORMATION

We have received a claim for services that appears to have been the result of an accidental injury or illness. To help us make a determination on the claim, please read and complete the enclosed form (called an incident letter), sign it, and return it to us in the envelope provided.

The incident letter **must be returned** in order for us to process the claim. If we can't process the claim, your provider may bill you directly. Once the completed incident letter is received, we will open a new claim file and process the previously denied claim based on the information you supply.

The incident letter assists us in appropriately processing potential injury claims, which helps to control the cost of health care coverage for all of our members. With your assistance, we can process claims quickly and efficiently making certain your providers are promptly reimbursed for services provided to you.

Automobile Accident

If you were involved in an automobile accident, your automobile insurance should pay first. This is because Utah is a no-fault state and requires that every driver carry minimum protection of \$3,000 in Personal Injury Protection (PIP). When the limits of your PIP coverage have been paid, your auto carrier will provide you with a letter (called an exhaust letter) and a document (called a PIP ledger) which will show which claims were paid by your auto carrier and which still need to be paid under your health contract. When you have those documents, please fax them to (801) 333-6508.

Work-Related Accident

If you have an injury or an illness that is work-related, the claims need to be submitted to your employer's workers compensation carrier.

Thank you for your cooperation. If you have any questions, please contact a Regence BlueCross BlueShield of Utah Customer Service specialist at (801) 333-2100 or toll-free 1 (800)-624-6519. You can also get a copy of the incident letter on our Web site at www.ut.regence.com in the **For Members** section under **Forms**.

INCIDENT REPORT

Date:

Patient:

ID No:

Clm. No:

Clm. Dt:

Name and address:

It has come to our attention that the above-named patient might have been injured in an accident or incident. Your Regence BlueCross BlueShield of Utah, Regence ValueCare and Regence HealthWise (Regence) health benefit plan includes a subrogation provision which allows Regence to recover payment for injuries caused by another party from that party, or from any settlement that results from claiming the injury. We ask that you complete the following questionnaire and return it within 15 days to avoid any delays, denials or incorrect payments. Please make certain that you, as the responsible party, read and understand the "Enrollee's Statement," sign the form and return it in the envelope provided. Please call (801) 333-2100 or toll-free 1 (800) 624-6519 with any questions. Thank you.

1. Briefly describe the circumstances that caused the patient to seek treatment: _____

2. Was this condition accident- or incident-related? **yes** **no** *If yes, what is the date, place and time of accident/incident?* _____

3. Briefly describe the resulting injuries: _____

4. To your knowledge, who was at fault? _____
 - a. Does patient intend to file a claim for personal injury? **yes** **no**
 - b. At fault party's insurance company, claim number, adjuster's name and phone number: _____

 - c. Has patient received settlement from at fault party? **yes** **no**
 - d. Is settlement anticipated? **yes** **no**
5. Has patient or responsible party retained a representing attorney? **yes** **no** *If yes, what is the attorney's name, phone number and address?* _____

If the injuries involved a motor vehicle, please answer the following questions:

6. Patient was (*please check one*): driver passenger working on an auto
 on a motorcycle pedestrian or bicyclist
 - a. Name and address of owner of vehicle with which patient was involved: _____

 - b. Insurance company, claim number and adjuster's name and phone number for above-mentioned vehicle: _____

continued

7. If patient was a passenger in someone else's vehicle, or was a pedestrian or bicyclist, does patient or responsible party have auto insurance on his/her vehicle? **yes** **no** *If yes, what is the insurance company, claim number, adjuster's name and phone number?* _____
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8. If patient is a resident of any state other than Utah, does patient or responsible party have Personal Injury Protection (PIP) or MedPay coverage on his/her vehicle? **yes** **no**
9. Was the at fault party driving his/her own vehicle? **yes** **no** *If no, what is the owner's name, insurance company, adjuster's name, claim number and phone number for this vehicle?* _____
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If the injuries were work-related, please answer the following questions:

10. Was patient on the job at the time of the incident? **yes** **no** *If yes, what is the employer's name, phone number and address?* _____
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11. Has patient reported this injury to his/her employer? **yes** **no**
- a. Is patient self-employed? **yes** **no**
12. Is patient covered through workers compensation insurance for this injury? **yes** **no**
- a. Has the injury claim been **denied**?* **accepted**? ** Please attach a copy of the denial letter.*
- b. If denied, does patient plan to appeal? **yes** **no**
- c. Workers compensation carrier, adjuster, claim number and phone number: _____
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Enrollee's Statement:

"I understand that if another party has injured me or any of my covered dependents, the benefits of my health benefit plan will be available to me or my covered dependents, subject to the terms, limitations, and exclusions of the plan. As a condition of those payments, I and/or my covered dependent agree to cooperate with Regence in its efforts to recover the benefits from the responsible party. I agree to reimburse Regence the amount of benefits paid as stated in the health benefit plan, subject to applicable law.

I hereby authorize Regence and anyone acting on its behalf to release any information about my accident and the benefits and medical service I received in connection with my accident to any persons who may be liable to:

- me, • my injured dependent, • Regence, and to:
- the insurance company of any such person, and • any insurance company that provides coverage for injuries related to this accident.

I further authorize my insurance company to release any information concerning my coverage to Regence.

I also authorize Regence review any workers' compensation claims files pertaining to me so that Regence can determine whether workers' compensation coverage is available for any of my injuries.

I certify that the information on this form is true and accurate to the best of my knowledge."

Enrollee Signature Date ID Number

Address Home Phone

Work Phone

Injured Dependent if 13 years or older/Guardian Signature Date Relationship