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 BlueCross BlueShield of South Carolina.

_____
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" Alpha Prefix)**

State Health Plan: AX-B10
ATTN: COB
P.O. Box 100605, Columbia, SC 29260-0605
Fax: 803-699-7675

- **Federal Employee Plan/FEP ("R" Alpha Prefix)**

Federal Employee Customer Service: AX-B05
P.O. Box 100603
Columbia, SC 29260-9982
Fax: 803-736-8341

- **Small Group and Individual ("ZCY" Alpha 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

Frequently Asked Questions

Why do we need this information?

Your health contract contains an important clause called "subrogation" or "reimbursement." This means when BlueCross BlueShield of South Carolina pays medical bills for an injury or illness that has been caused by a third party, we have a right to seek reimbursement of those medical bills from the third party, their insurance company, and/or your insurance company. We also have the right to seek reimbursement of the medical bills from you if you receive a settlement from the third party or an insurance company for this injury or illness.

How did we identify your claim as a potential subrogation or workers' compensation case?

Our staff of physicians has established a list of diagnosis codes that indicate an injury or illness may be accident related or work related. When claims are processed through our system, a questionnaire is generated if the patient has received treatment for an injury or illness that has one of these "accident-type" diagnosis codes.

How does subrogation help you?

These subrogation/reimbursement procedures help to contain the cost of healthcare by reducing premium costs paid by you and/or your employer and also reducing the amount of benefits applied to your lifetime maximum benefit amount.

What if you were injured on the job?

Your health contract also contains a provision that excludes the payment of medical bills for work-related injuries and illnesses. This means that we will not provide benefits if workers' compensation laws cover, provide or pay for the service, supply or treatment of any work-related accident or illness. In addition, if you receive a settlement for your workers' compensation claim, we consider the settlement payment to be covered by workers' compensation and we will not provide medical benefits for the injury or illness.

Does this questionnaire only apply to work-related accidents?

No. If another person caused your injury or illness or may be responsible for your injury or illness, you need to complete this form. We cannot provide you with an entire list, but here are just a few of the types of accidents we need to know about: car accidents, motorcycle accidents, work-related injuries, injuries on another person's property (such as falling in the grocery store), medical malpractice, defective products or machinery, food poisoning, etc.

What if this claim was not accident related or if no one else was responsible for the injury or illness?

The only way we will know if your claims are or are not accident related is if you complete and return this form. After we receive your information indicating this was an illness for which no one else is responsible, we will make sure your claims are opened for processing and we will notate your information in our system to avoid having future questionnaires sent to you for the same accident.

What do you need to do?

It is very important that you complete this easy questionnaire and send it back to us. Your answers will help us properly administer your claims and determine if we need to seek reimbursement from a third party or an insurance company for these claims. If you do not return the questionnaire, we may withhold payment on your medical claims.

The subrogation/reimbursement and workers' compensation clauses in your health contract require you to notify us if you receive an award or settlement from a third party or an insurance company. From that award or settlement, you must reimburse BlueCross BlueShield of South Carolina for any medical benefits that we have paid for this injury or illness.

What if you still have questions or need help completing this form?

Please contact us at 1-800-288-2227, extension 43060, for more assistance.