



**BlueCross BlueShield
of Florida
Health Options®**

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

Member Name:
Address:
City, State, Zip:
Phone #:
Contract #:
Date of Accident: Date of Service:

Dear Insured:

If you have recently experienced a claim related to an accident, you may use this form to furnish Blue Cross Blue Shield of Florida (BCBSF) / Health Options, Inc. (HOI) information related to the claim. Your claim may have occurred due to a potential on the job injury/illness or an automobile accident. BCBSF/HOI works hard to keep health care costs down by making sure that when another insurance or other party is liable, they pay their share. Please help us to keep health care costs down by providing the information requested below. **Complete, sign, and return the questionnaire within 30 days. A prompt response will ensure accurate processing of future claims. You should mail the completed form to the address indicated above. Thank you.**

Was the claim indicated above related to an on the job injury/illness, automobile accident, or does another party have liability? Yes No

- 1. If the answer is No, please provide a brief description of what the claim was related to and complete Section A:**
- 2. If the answer is Yes, please complete Section A and the Appropriate Section(s) B - D that follow, which pertains to the injury/illness or accident.**

SECTION A:

To the best of my knowledge the information is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to BCBSFL/HOI all records necessary for processing claims filed by me or on my behalf.

Date: _____ Subscriber's Signature: _____

Home Phone #: _____ Work Phone #: _____

SECTION B:

If your injury was auto-related, please complete this section and provide a copy of the accident report.

1. Date and location of your accident: _____

2. Has a claim been made to your auto insurance carrier? ___ Yes ___ No

3. Please provide the following information:

Name of Auto Insurance: _____

Mailing Address: _____

Phone Number: _____

Policy #: _____

Claim #: _____

4. Do you have a No-Fault deductible? ___ Yes ___ No
If yes, please provide a copy of your automobile coverage limits.

5. Were you a guest passenger in another vehicle? ___ Yes ___ No

SECTION C:

If your injury/illness was job-related, please complete this section.

1. What was the initial date and cause of the injury/illness? _____

2. For what condition were you treated? _____

3. Has a Workers' Compensation claim been filed by your employer? ___ Yes ___ No
If yes, has the case been accepted or denied? _____

Please provide documentation to support either decision and complete the following information:

Case or Claim #: _____

Carrier's Name: _____

Mailing Address: _____

Phone Number: _____

4. If you indicated that a workers' compensation claim was not filed by your employer please explain why, and provide any documents that you might have:

5. Are you self-employed? ___ Yes ___ No
If yes, please provide the name of your Workers' Compensation carrier:

SECTION D:

If there is a possibility that another party may be responsible for your accident or injury/illness (potential lawsuit), please complete this section.

1. Date of accident or injury/illness: _____

2. Type of accident or injury/illness: ___Auto Accident ___Slip & Fall ___Malpractice
If none of the above, how did the injury occur? _____

3. Please provide the insurance information for the individual who caused the accident or injury/illness:
Name of Insurance Company: _____
Mailing Address: _____
Responsible Party: _____
Policy #: _____

4. Have you sought the assistance of an attorney? ___Yes ___No
If yes, please provide the following:
Attorney's Name: _____
Mailing Address: _____
Phone Number: _____