SUBROGATION/WORKERS' COMPENSATION QUESTIONNAIRE

0L SUQ

Subscriber Name _____

I.D. Number _____

Phone Number
(h)_____(w)_____

BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association

Your health coverage contains language regarding subrogation and contractual right of recovery, which allows us to pursue recovery of benefits that have been paid for injury or illness when another party is responsible. This language also requires that you cooperate and do what is reasonably necessary to help us obtain this recovery.

Please complete this questionnaire and return it to:

Blue Cross and Blue Shield of Nebraska
Attention Subrogation/Workers' Compensation
P.O. Box 3248
Omaha, NE 68180-0001

We know your time is valuable and we appreciate your help in this matter. Should you have any questions, please call **390-1847 or 1-800-662-3554.** Thank you in advance for your cooperation in this matter.

Our records indicate the health services received are possibly due to an accident, an injury caused by another party or to a work-related injury. Please provide the following information:

Patient name: _____

1. Were services received due to an accident? Yes____ No____

   Please describe how the accident took place. (If not an accident, please indicate why care was received).

   _____

   _____

   _____

NOTE: If you answered NO to Question #1 and explained why care was received, please sign where indicated on page 2 of this form and return it to us. If you answered YES to Question #1, please continue.

2. Date of accident or illness:_____

3. Please describe the injuries received as a result of this accident.

   _____

   _____

4. Were services the result of an auto accident? Yes____No____

5. Names of any other family members injured: _____

   _____

6. Were services work-related? Yes____No____

   If work-related, provide name of employer: _____

7. Is another party responsible for payment of these services? (for example: assault, medical malpractice, dog bite, fall on someone's property, product negligence, food poisoning)

   Yes____No____

8. Indicate type of accident:_____

9. If another party is responsible, please provide the following information:

   Responsible party's name:_____

   Their insurance company's name:_____

   Address:_____

   Phone number:_____ Agent name:_____

   Their claim or policy number:_____

10. Have you retained an attorney? Yes____No____

    If yes, name, address and phone number of attorney:

    _____

    _____

    _____

Signature _____ **Date** _____