Subrogation Questionnaire

When another party is responsible for an injury or illness that resulted in Blue Cross and Blue Shield of Nebraska (BCBSNE) paying benefits, we pursue recovery of those payments from that other party. Your health coverage contains provisions requiring that you provide reasonably necessary assistance in this recovery effort. We know your time is valuable, and we appreciate your help in this matter.

Please complete this questionnaire and return it to:

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

If you have any questions, please call **402-390-1847 or 800-662-3554.**

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 the 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.

   ____
   ____
   ____

   If you answered No to question number 1 and explained why care was received, please sign where indicated on page 2 and return this form to us. If you answered Yes to question number 1, please continue to the next question.

2. Date of accident or illness: ______________________________

3. Please describe the injuries recieved as a result of this accident or illness?

   ____
   ____

4. Were the services the result of an auto accident? ☐ Yes ☐ No

5. Name of any other family members injured: ______________________________

6. Were the services work-related? ☐ Yes ☐ No

   If work-related, please provide name of employer: ______________________________

7. Indicate type of accident: ______________________________

   (for example: assault, medical malpractice, dog bite, fall on someone's property, product negligence, food poisoning)

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8. Is another party responsible for payment of these services? ☐ Yes ☐ No

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, please provide name, address and phone number of attorney:

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____________________ ____________________

Signature *Date*

Internal Use Only	Subscriber Name: ____________________	Home Phone: ____________________
	ID Number: ____________________	Work Phone: ____________________

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