Workers' Compensation Questionnaire

Our records indicate that you or a family member may have experienced an injury or illness arising out of and in the course of your employment. For us to process your health benefits properly, we need some additional information. Please take a few minutes to respond to this questionnaire and return the completed form to:

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

Fax: 402-392-4206

Patient Name: _____

1. Did your injury or illness occur while you were working? ☐ Yes ☐ No

   If no, please sign where indicated below and return this form.
   If yes, please complete the remainder of this form before returning it to us.

2. Date of injury or illness: _____

3. Type of injury or illness (chief complaints): _____

   _____

4. How did the injury or illness occur? _____

   _____

5. Are you self-employed? ☐ Yes ☐ No

   If yes, have you elected Workers' Compensation coverage? ☐ Yes ☐ No

6. Have you retained an attorney? ☐ Yes ☐ No

   If yes, please provide their name and address: _____

   _____

7. Name of employer: _____

8. Has the employer or its Workers' Compensation carrier accepted or denied this claim? ☐ Accepted ☐ Denied

   If accepted, has this case been settled: ☐ Yes ☐ No

   If settled, please provide a copy of the settlement. If denied, please provide a copy of the denial letter.

   Name of Workers' Compensation carrier: _____

   Address of Workers' Compensation carrier: _____

   Name of Adjuster: _____

   Adjuster's Phone Number: _____

   Work Comp. Claim Number: _____

_____ _____

Signature *Date*

Internal Use Only

Subscriber Name: _____ Home Phone: _____

ID Number: _____ Work Phone: _____