WORKERS' COMPENSATION QUESTIONNAIRE

BlueCross BlueShield of Nebraska

A Not-For-Profit Mutual Insurance Company and an Independent Licensee of the Blue Cross and Blue Shield Association.

1Z WCQ

Subscriber Name _____

I.D. Number _____

Phone Number
(h)_____ (w) _____

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. In order to process your health benefits properly, we need additional information. Please take a few minutes to respond to this questionnaire.

When you have completed this form, either fax it to 402-392-4206 or mail to:

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

Patient name: _____

1. Did your injury or illness occur while working? YES _____ NO _____

If NO, please sign where indicated at the bottom of this form, and return to us. If YES, please complete the remainder of this form before returning it to us.

2. Date of injury/illness: _____
3. Type of injury/illness (chief complaints): _____

   _____
4. How did the injury/illness occur? _____

   _____
5. Are you self-employed? YES _____ NO _____

   If yes, have you elected Workers' Compensation coverage? YES _____ NO _____
6. Have you retained and attorney? YES _____ NO _____

   If so, provide the name and address of the attorney: _____

   _____
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.

Signature _____ Date _____