Subrogation / Workers' Compensation
I-20 at Alpine Road
Columbia, SC 29219-0001
1-800-288-2227, extension 43060
Fax: 1-803-865-0654

BlueCross BlueShield Of South Carolina
An independent licensee of the Blue Cross and Blue Shield Association

ACCIDENT QUESTIONNAIRE

Subscriber: _____
Address: _____
Address: _____

Patient: _____
Identification No.: _____
Provider: _____
Date of Service: _____
Group Number: _____
Claim Number: _____
Claim Amount: _____

Dear Member:

Our review process indicates this patient may have received healthcare services related to an accident. So we may evaluate our responsibility, please complete, sign and return this form within five days of receipt. If we do not receive this information, we may have to deny your claims. **If you have previously completed a form for this accident, please check here _____ and update.**

Was the injury or illness: **Auto/Motorcycle Accident____Work Related____Other Accident____No Accident ____**
Date of the injury or illness: _____ City/County and State of Injury: _____
Describe the injury or illness and how it happened: _____
_____
Names of other family members injured:_____

If you checked "Auto/Motorcycle Accident" or "Other Accident," please answer the following:

Did another person cause this accident? YES / NO
If yes, name and address of person causing injury: _____
Insurance Company of person causing injury:_____ Policy/Claim # :_____
Address and Phone #:_____ Adjuster's Name:_____
If auto or motorcycle related, was the patient wearing a seatbelt? YES / NO a helmet? YES / NO
If auto or motorcycle related, was the patient the driver _____ or a passenger _____ ?
Auto Insurance Company of Patient: _____Policy/Claim #:_____
Address and Phone #:_____ Adjuster's Name:_____

If you checked "Work Related," please answer the following:

Name and address of patient's employer at the time of injury: _____
Have you filed a Workers' Compensation claim? YES / NO
If yes, name of Workers' Compensation carrier:_____
Policy/Claim # : _____ Adjuster's Name:_____
Address and Phone #_____
Has the employer or the workers' compensation carrier accepted or denied liability? ACCEPTED / DENIED

Name, address, and telephone number of your attorney (if applicable): _____
_____

I agree that the above information is correct, and I will not settle a claim before contacting the Subrogation / Workers' Compensation Department of BlueCross BlueShield of South Carolina.

_____
Signature Date Telephone Number

ALL QUESTIONS ON THIS FORM MUST BE ANSWERED

DATE: _____ YOUR SOCIAL SECURITY # _____ / _____ / _____

NAME: _____ HOME PHONE: (_____) _____ - _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ AGE: _____

(CIRLCE ONE) SEX: M F BIRTHDATE: _____ / _____ / _____

MARITAL STATUS: MARRIED SINGLE WIDOW SEPERATED DIVORCED

IF MARRIED, GIVE SPOUSE'S NAME: _____

IF SINGLE, GIVE FATHER'S OR MOTHER'S NAME: _____

EMPLOYER: _____ PHONE: (_____) _____ - _____

EMPLOYER ADDRESS: _____

ARE YOU COVERED BY HEALTH INSURANCE? YES NO

NAME OF INSURANCE COMPANY: _____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? YES NO

IF YES, GIVE DATE: _____ WERE YOU INJURED? YES NO

IF INJURED, WHERE: NECK BACK HEAD OTHER: _____

WHAT DOCTOR DID YOU SEE FOR ABOVE ACCIDENT? _____

By signing you name below, you certify the accuracy of your medical and/or accident history and further certify that you present to the doctor for evaluation and/or treatment of a health related condition and for no other purpose.

I hereby request and consent to the performance of medical/chiropractic care by this office. I understand and am informed that there are some risks to diagnoses and treatments. I wish to rely on the doctor to exercise judgement during the course of the procedure to act in my best interest. I have read or have had read to me, the above consent. By signing below, I consent to Lancaster One Medical to perform necessary diagnosis and treatment procedures.

Parent's Signature: _____

Authorization to Treat Minor: _____

(Over)

DATE OF CURRENT ACCIDENT: _____ TIME: _____ AM/PM

DATE OF FIRST SYSTEMS: _____

LOCATION OF ACCIDENT? (*ON WHAT HIGHWAY OR ROAD*): _____

_____

HAVE YOU LOST ANY TIME FROM WORK DUE TO THIS ACCIDENT OR SICKNESS? YES NO

IF YES, DATES FROM _____ TO _____

WHERE DO YOU HURT?

- □ HEADACHE
- □ MID BACK PAIN
- □ PAIN BETWEEN SHOULDERS
- □ RIGHT LEG / HIP PAIN
- □ RIGHT ARM / SHOULDER

CHECK SYSTEMS YOU ARE HAVING:

- □ NECK PAIN
- □ LOW BACK PAIN
- □ CHEST PAIN
- □ LEFT LEG / HIP PAIN
- □ LEFT ARM / SHOULDER
- □ NECK STIFF
- □ FATIGUE
- □ DIZZINESS
- □ NERVOUSNESS
- □ NAUSEA

HOW DID ACCIDENT HAPPEN? _____

WERE YOU THE □ DRIVER □ PASSENGER □ PEDESTRIAN

DID YOU/DRIVER GET A TICKET? YES NO OTHER DRIVER? YES NO

WERE YOU WEARING A SEAT BELT? YES NO

DID ANY PART OF YOUR BODY HIT ANYTHING DURING ACCIDENT? YES NO

IF YES, WHAT BODY PART? _____

DID YOUR CAR HIT THE OTHER CAR? YES NO DID OTHER CAR HIT YOURS? YES NO

AT THE TIME OF ACCIDENT, WERE YOU LOOKING □ AHEAD □ LEFT □ RIGHT

DID YOU GO TO THE EMERGENCY ROOM? YES NO

IF YES, WHEN? □ AFTER ACCIDENT □ SAME DAY □ SAME NIGHT □ LATER

HOW DID YOU GO? □ AMBULANCE □ CAR WHICH HOSPITAL? _____

WHERE YOU ADMITTED? YES NO IF YES, DATE ADMITTED: _____

DATE RELEASED: _____

WERE X-RAYS TAKEN? YES NO IF YES, WHAT BODY PART? _____

HAVE YOU SEEN ANY OTHER DOCTOR FOR THIS ACCIDENT? YES NO

IF YES, GIVE DOCTOR'S NAME: _____

HIS DIAGNOSIS: _____

_____