

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



South Carolina

*BlueCross BlueShield of South Carolina
is 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

Frequently Asked Questions

Why do we need this information?

Your health contract contains an important clause called “subrogation” or “reimbursement.” This means when BlueCross BlueShield of South Carolina pays medical bills for an injury or illness that has been caused by a third party, we have a right to seek reimbursement of those medical bills from the third party, their insurance company, and/or your insurance company. We also have the right to seek reimbursement of the medical bills from you if you receive a settlement from the third party or an insurance company for this injury or illness.

How did we identify your claim as a potential subrogation or workers’ compensation case?

Our staff of physicians has established a list of diagnosis codes that indicate an injury or illness may be accident related or work related. When claims are processed through our system, a questionnaire is generated if the patient has received treatment for an injury or illness that has one of these “accident-type” diagnosis codes.

How does subrogation help you?

These subrogation/reimbursement procedures help to contain the cost of healthcare by reducing premium costs paid by you and/or your employer and also reducing the amount of benefits applied to your lifetime maximum benefit amount.

What if you were injured on the job?

Your health contract also contains a provision that excludes the payment of medical bills for work-related injuries and illnesses. This means that we will not provide benefits if workers’ compensation laws cover, provide or pay for the service, supply or treatment of any work-related accident or illness. In addition, if you receive a settlement for your workers’ compensation claim, we consider the settlement payment to be covered by workers’ compensation and we will not provide medical benefits for the injury or illness.

Does this questionnaire only apply to work-related accidents?

No. If another person caused your injury or illness or may be responsible for your injury or illness, you need to complete this form. We cannot provide you with an entire list, but here are just a few of the types of accidents we need to know about: car accidents, motorcycle accidents, work-related injuries, injuries on another person’s property (such as falling in the grocery store), medical malpractice, defective products or machinery, food poisoning, etc.

What if this claim was not accident related or if no one else was responsible for the injury or illness?

The only way we will know if your claims are or are not accident related is if you complete and return this form. After we receive your information indicating this was an illness for which no one else is responsible, we will make sure your claims are opened for processing and we will notate your information in our system to avoid having future questionnaires sent to you for the same accident.

What do you need to do?

It is very important that you complete this easy questionnaire and send it back to us. Your answers will help us properly administer your claims and determine if we need to seek reimbursement from a third party or an insurance company for these claims. If you do not return the questionnaire, we may withhold payment on your medical claims.

The subrogation/reimbursement and workers’ compensation clauses in your health contract require you to notify us if you receive an award or settlement from a third party or an insurance company. From that award or settlement, you must reimburse BlueCross BlueShield of South Carolina for any medical benefits that we have paid for this injury or illness.

What if you still have questions or need help completing this form?

Please contact us at 1-800-288-2227, extension 43060, for more assistance.

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188]。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보법에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره ی این برنامه ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
