Blue Cross Blue Shield of North Dakota is an independent licensee of the Blue Cross & Blue Shield Association

Fax to: (701) 297-1641
Mail to: BCBSND
Attn: COB
4510 13th Ave S
Fargo, ND 58121

Workers Compensation / No Fault / Subrogation

This form should be completed by the Member to determine if other coverage is responsible for any claim(s) incurred. If the requested information is not received, claim processing may be delayed. For questions, contact Member Services at the number listed on the insurance card. ***If your injuries were caused by a third party, you are obligated under your benefit plan to notify and reimburse BCBSND for any money received from the third party for benefits paid for your injury.***

Patient Name: _____ Benefit Plan Number: _____

Current Address: _____ Home Phone #: _____ Work Phone #: _____

Provider Name: _____ Date of Injury: _____ Date of Service: _____

If there is no Attorney involvement, contact BCBSND prior to a settlement.
If you have consulted an Attorney regarding this accident, please provide the following information:
Attorney Name: _____ Address: _____ Phone #: _____

Briefly describe the condition, incident, or injury: _____

_____

Body part(s) injured/treated**:** _____

Complete the appropriate section(s) related to your services.

WORKERS COMPENSATION – services were a result of an employment-related injury or condition

Employer Name: _____
Do you intend to submit a claim to Workers Compensation? ( ) Yes ( ) No
If **No**, please explain why: _____
If **Yes**, WC carrier name: _____ WC Phone #: _____ WC Claim #: _____

MOTOR VEHICLE ACCIDENT – services were a result of an injury involving a motor vehicle

Type of accident: ( ) Car ( ) Motorcycle ( ) Other, Please specify: _____
Were you the: ( ) Driver ( ) Passenger ( ) Pedestrian
Location of accident: City _____ State _____
Was another driver at fault? ( ) Yes ( ) No
If **Yes**, do you intend to submit a claim to their insurance company? ( ) Yes ( ) No
Information regarding the driver of the other vehicle:
Owner's Name: _____ Insurance Company: _____ Phone Number: _____
Were any of your family members injured in this accident? ( ) Yes ( ) No
If **Yes**, list their first names: _____
Do you have vehicle insurance? ( ) Yes ( ) No
If **Yes**, provide the following information regarding your insurance:
Insurance Company: _____ Policy Number: _____
Address: _____ Phone Number: _____

OTHER ACCIDENT – services were a result of an accident or injury occurring on someone else's property

Is this a military injury? ( ) Yes ( ) No
If **Yes**, disregard the following questions
Does the property owner have insurance to cover medical expenses? ( ) Yes ( ) No
If **Yes**, do you intend to submit a claim to that insurance company? ( ) Yes ( ) No
If **Yes**, provide the following information regarding the legal property owner where the accident occurred:
Property Owner's Name: _____
Insurance Company: _____ Phone Number: _____

I certify the information given on this form is accurate to the best of my knowledge.

Member's Signature: _____ Date: _____