ND

Mail completed form to:

Blue Cross Blue Shield of North Dakota
4510 13th Ave S, Fargo, ND 58121

Workers Compensation/No Fault/Subrogation

Our records indicate the health services received are possibly due to a work-related injury, a motor vehicle accident, or an injury caused by another party. In order to process your health benefits properly, please complete, sign and return this form within seven days of receipt. If we do not receive the requested information, the processing of your claims may be delayed. If you have any questions or prefer to provide this information over the phone, please call the number on the back of your insurance card.

Patient Name: _____ Benefit Plan Number: _____

Claim Number: _____ Date of Service: _____

Required information

Date of injury or onset of symptoms: _____

Body part(s) injured/treated: _____

Briefly describe the condition, incident, or injury: _____

COMPLETE THE APPROPRIATE SECTION(S) RELATED TO YOUR SERVICES.

Workers Compensation (WC)

Were these services a result of an employment-related injury or condition? ☐ **Yes** ☐ **No**

If Yes, provide the following information:

Employer Name: _____

Do you intend to submit a claim to Worker's Compensation? ☐ Yes ☐ No

If Yes, WC carrier name: _____

WC Claim Number: _____ WC Phone Number: _____

If the injury or condition occurred at work and you do not file to WC, BCBSND may deny your claims.

If No, please explain why: _____

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Motor Vehicle Accident

Were these services a result of an injury involving a motor vehicle? ☐ **Yes** ☐ **No**

If Yes, provide the following information:

Type of Accident: ☐ Car ☐ Motorcycle ☐ Other:_____

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 that insurance company? ☐ Yes ☐ No

Information regarding the driver of the other vehicle

Owner's Name: _____

Insurance Company: _____ Insurance Company Phone Number:_____

Insurance Company Address: _____

City:_____ State:_____ Zip:_____

Policy/Claim Number:_____

Were any of your family members injured in this accident? ☐ Yes ☐ No

If Yes, list their first names: _____

Do you have auto insurance? ☐ Yes ☐ No

If Yes, provide the following information regarding your auto insurance:

Insurance Company: _____ Insurance Company Phone Number: _____

Insurance Company Address: _____

City: _____ State:_____ Zip: _____

Policy/Claim Number: _____

Other Accident

Were these services a result of an accident or injury occurring on someone else's property? ☐ **Yes** ☐ **No**

If Yes, provide the following information:

Is this a military injury? ☐ Yes ☐ No

If yes, did the injury occur while on weekend duty? ☐ Yes ☐ No

If no, did the injury occur while on active duty? ☐ Yes ☐ No

If yes, please provide dates of active duty:_____

Patient Name: _____ Benefit Plan Number: _____

If the accident is a result of a military injury, please 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: _____ Insurance Company Phone Number: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Policy/Claim Number: _____

Attorney and Settlement Information

Please contact Member Services at the number listed on the back of your insurance card prior to a settlement, even if there is no Attorney involvement.

If you have consulted an Attorney regarding this accident, please provide the following information:

Attorney Name: _____ Attorney Phone Number: _____

Attorney Address: _____

City: _____ State: _____ Zip: _____

Signature

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

Member's Signature: _____ Date: _____

Please provide current contact information

Home Phone Number: _____ Work Phone Number: _____

If your address has changed, please call the number on the back of your insurance card to update or call your employer to update.