BlueCross BlueShield of Oklahoma
1215 South Boulder • PO Box 3283 • Tulsa, OK 74102-3283

ACCIDENTAL INJURY QUESTIONNAIRE

COMPLETION OF THIS QUESTIONNAIRE BY THE INSURED WILL EXPEDITE THE PROCESSING OF RELATED CLAIMS

SUBSCRIBER ID NO.	SUBSCRIBER NAME
PATIENT NAME (PLEASE PRINT)	
DATE OF CARE	PHYSICIAN NAME

IN ORDER TO MAKE A BENEFIT DETERMINATION, WE MUST HAVE THE FOLLOWING INFORMATION FROM THE INSURED:

1. IS THIS CARE RELATED TO AN ACCIDENTAL INJURY? ☐ YES ☐ NO IF YES, IS THIS A NEW INJURY OR A PREVIOUS INJURY?

2. IF THIS WAS A PREVIOUS INJURY, PLEASE PROVIDE NAME AND ADDRESS OF THE ATTENDNG PHYSICIAN PROVIDING TREATMENT FOR THE PREVIOUS INJURY

PHYSICIAN'S NAME PHYSICIAN'S ADDRESS

3. IF THIS IS A NEW INJURY, ON WHAT DATE DID IT OCCUR? (MONTH/DAY/YEAR)

4. WHAT TYPE OF NEW INJURY IS THIS?

☐ AUTO ☐ MOTORCYCLE ☐ WORK-RELATED ☐ INTERSCHOLASTIC SPORTS ☐ OTHER (PLEASE SPECIFY)

5. WHERE DID THE NEW INJURY OCCUR?

6. HOW DID THE NEW INJURY OCCUR?

7. IS ANOTHER PERSON OR ORGANIZATION RESPONSIBLE FOR THIS NEW INJURY? ☐ YES ☐ NO IF YES, PLEASE PROVIDE NAME AND ADDRESS

I HEREBY CERTIFY THAT MY ANSWERS ARE COMPLETE AND ACCURATE.

REMINDER: IT IS A VIOLATION OF OKLAHOMA STATE LAW TO GIVE FALSE INFORMATION TO AN INSURANCE COMPANY.

PATIENT SIGNATURE DATE

For physician office use only:

Physician Name (Please print): _____

Physician's 12-digit billing no: _____

Return this completed form to Blue Cross and Blue Shield of Oklahoma
Attn: Supervisor, WC
PO Box 3283
Tulsa, Oklahoma 74102-3283
Or fax to: (918) 560-7865- Attn: Supervisor, WC

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