

Other Party Liability

Patient Information Form

Phone: 785-291-4013 option 5
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www.bcbsks.com



Section 1

Member Name _____
Last First MI

Member's ID No. _____ Provider _____

Patient Name _____
Last First MI

Section 2

Annually, Blue Cross and Blue Shield of Kansas verifies whether or not your family has duplicate coverage. *If it has been a year since your last visit to this provider, please answer the following:*

1. Are you, your spouse or your dependent children enrolled in other group health insurance (**not** Medicare or SRS/Medicaid)? Yes No

If Yes: Name of Policyholder _____
Name, address and phone number of other insurance company _____
ID No., Group and/or Policy No. _____
Employer/Group _____

Section 3

We also attempt to verify if injuries, carpal tunnel, heart attacks, hernias and back problems are eligible to be covered by worker's compensation or auto insurance. If your visit is related to an injury or one of the conditions described above, please answer the following questions *unless this is a follow-up visit and you have filled out this form previously.*

2. Date of accident or onset of symptoms _____

3. Description of injury (body part) or condition _____

4. How did injury/condition occur? _____

5. Where did it occur? School Home Work
 Other (explain) _____

6. Was your accident/condition work related? Yes No

If Yes, are you self-employed? Yes No

7. Was the injury the result of a motor vehicle accident or of physical contact with a motor vehicle? Yes No

If Yes, type of vehicle involved: Car Truck Motorcycle

If Motorcycle: a. Are you the owner? Yes No

b. **If you are the owner,** does your motorcycle insurance include coverage for medical expenses (Personal Injury Protection)? Yes No

8. Was another party responsible for your injury or condition? Yes No

If Yes, explain: _____

Coordinating benefits places responsibility with the proper carrier, which helps keep rates lower for our customers.

Your signature required

Date _____/_____/_____