Other Party Liability
Patient Information Form

Phone: 785-291-4013 option 5
Fax: 785-291-8981
Maildrop: 217D5
www.bcbsks.com

Section 1

Member's Name: ______________________________ (Last / First / M.I.)

Member's ID #:: ______________________ Provider: ______________________

Patient's name: ______________________________ (Last / First / M.I.)

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, SRS/Medicaid) for medical or dental expenses? ❑ Yes ❑ No

If Yes: Name of Policyholder: ______________________

ID#, group and/or policy#: ______________________

Employer/group: ______________________

Section 3

We also attempt to verify if injuries, carpel 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: ______________________

Section 4

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

Signature : ______________________ Date: ____________

*An Independent Licensee of the Blue Cross and Blue Shield Association.