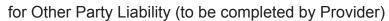
## **Patient Information Form**





Section 1 – Member Information				
First Name M	11	Patient First Name		MI
Last Name		Patient Last Name		
Member ID Number		Provider		
Section 2 – Other Coverage Information				
Annually, Blue Cross and Blue Shield of Kansas verifibeen a year since your last visit to this provider, pleas		• • • • • • • • • • • • • • • • • • • •	verage. I	f it has
Are you, your spouse or your covered dependent children enrolled in other insurance (medical, dental, vision or prescription – NOT Medicare, SRS/Medicaid)?  ☐ Yes ☐ No		Name of Other Insurance Company		
		Address of Other Insurance Company		
If you answered Yes, please complete all remaining questions in this section.		City		
		State ZIP Code Other In	nsurance P	hone
Policyholder First Name M	11	Identification Number through which the policy is	provided	
Policyholder Last Name		Group Number through which the policy is provide	ed (if applic	able)
Policy Number		Employer or Group through which the policy is pro	ovided (if ap	pplicable)
Section 3 – Information About Injury				
We also attempt to verify if injuries, carpel tunnel, hea covered by worker's compensation or auto insurance. described above, please answer the following question form previously.	. If yo	our visit is related to an injury or one of the	e condition	ns
Date of Accident/Onset of Symptoms		Was your accident or condition work related?	□Yes	□ No
Description of Injury (Body Part) or Condition		If Yes, are you self-employed?	☐Yes	□No
How did the injury or condition occur?		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		
Where did the injury or condition occur?	-	If motorcycle, are you the owner?	☐ Yes	□No
☐ School ☐ Home ☐ Work ☐ Other		If you are the owner, does your motorcyc insurance include coverage for medical expenses (Personal Injury Protection)?	cle □ Yes	□No

Please continue on the next page.

Section 3 – Information About Injury (continued)	
Was another party responsible for your injury or condition? $\hfill \square$ Yes $\hfill \square$ No	
If Yes, please explain:	
NOTE: Coordinating benefits places responsibility with the proper carrier, which helps keep rates lower for our customers.	
Section 4 – Authorization	
Your signature required Applicant	Date Signed

## **Questions?** Please contact Other Party Liability at:

Toll Free: (800) 430-1274 or in Topeka, (785) 291-4013 By mail at: 1133 SW Topeka Blvd.

Fax: (785) 290-0771 Mailstop 217E1

Online: bcbsks.com

Topeka, KS 66629-0001