ACCIDENT REPORT

PacificSource
HEALTH PLANS

PO Box 7068
Eugene, Oregon 97401
(541) 686-1242 • (800) 624-6052
Fax (541) 684-5253
www.pacificsource.com

IMPORTANT MEDICAL SERVICE QUESTIONNAIRE: PLEASE COMPLETE AND RETURN
Please use only blue or black ink.

Para la ayuda en español, llame (800) 624-6052, extensión 1009.

Date Sent: ____________________ **Body Part:** ____________________

Patient Name: ____________________ **Claim Number:** ____________________

Member Number: ____________________ **Date of Service:** ____________________

We need your help to process claims correctly. Please complete and return this form *within 15 days.* Without this information, claims payment may be delayed or denied. For *any* injury or medical condition, please answer the first six questions. The remaining questions only need to be answered if the injury or medical condition resulted from an automobile accident or occurred while on the job. This information is required for each new injury or condition.

SECTION ONE: CIRCUMSTANCES

1. Briefly describe the circumstances that caused you to seek treatment. *If more room is needed, you may use the back of this form or attach a separate document.*

2. Date when injury or condition occurred:

3. To your knowledge, who was at fault?

4. Where did the accident or injury occur (other than at home)?

5. List insurance name and address (other than PacificSource) and adjuster name and phone number:

6a. Has the patient consulted an attorney?
☐ Yes ☐ No

6b. If yes, provide the attorney's name, address, and phone number:

SECTION TWO: INJURIES INVOLVING A MOTOR VEHICLE

7. Was your automobile at fault?
☐ Yes ☐ No

8. Was the patient *(please check all that apply)*:
☐ In an automobile ☐ On a motorcycle ☐ Other: ____________
☐ The driver ☐ A passenger ☐ A pedestrian or on a bicycle
☐ Working on the auto

9. If the patient was a passenger, please list the name and address of the vehicle's driver, as well as the name and address of insurance company covering the motor vehicle, the claim number, and the name and phone number of adjuster:

10. If another motor vehicle was involved, please list the name and address of that vehicle's driver, as well as the name and address of the insurance company covering the motor vehicle, the claim number, and the name and phone number of adjuster:

11. If you are a resident of any state other than Oregon, do you have personal injury protection (PIP) on your vehicle?
☐ Yes ☐ No ☐ I'm an Oregon resident

If you are not an Oregon resident, please enclose a copy of the ***Declaration Page*** *from your policy. If your benefit is exhausted, please enclose a copy of your payment ledger for all available PIP/Med pay. If you have questions regarding PIP/Med pay, please contact your auto insurance carrier.*

Continued on page two—a signature is required. Unsigned forms will be returned.

SECTION THREE: INJURIES OCCURRING ON THE JOB	
12. Did the injury or medical condition occur as a result of employment or while the patient was working? *If yes, please complete questions 13 through 17.*	☐ Yes ☐ No
13. Please provide the employer's name and address:	
14. Has the patient reported this injury or medical condition to his or her employer?	☐ Yes ☐ No
15. Is the patient self-employed?	☐ Yes ☐ No
16. Has the patient filed a workers' compensation claim? Has the workers' compensation claim been denied? *If yes, attach a copy of the denial* If answer is yes, does the patient plan to appeal?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
17. Carrier name and address, claim number, and the adjuster's name and telephone number:	

I hereby authorize PacificSource Health Plans and anyone acting on its behalf to release any information about my accident and the benefits and medical service I received in connection with any accident to any persons who may be liable to:

- me;
- my injured dependent;
- the insurance company of any such person;
- PacificSource Health Plans; and
- any insurance company providing coverage for injuries related to this accident.

I further authorize my insurance company to release any information concerning my coverage to PacificSource. I also authorize PacificSource to review any workers' compensation claims files pertaining to me to determine whether workers' compensation coverage is available for any of my injuries.

I certify that the information on this form is true and accurate to the best of my knowledge.

I have the right to revoke this authorization in writing at any time. If I revoke my authorization, the information will no longer be used or disclosed for the reasons covered by this written authorization. Any uses or disclosures already made with my permission cannot be taken back. Unless revoked, this authorization will be in force until the purpose of this authorization has been completed, but not longer than 24 months.

To revoke this authorization, send a written statement that you are revoking this authorization to:

PacificSource Health Plans
Attn: Third Party Recovery Department
PO Box 7068
Eugene, OR 97401-9716

Please note: If this authorization is revoked, claims could be denied due to insufficient information.

Member Signature ____________________ Member Identification No. ____________________ Date ____________

Street Address ____________________ Home Phone Number ____________

City, State, and Zip ____________________ Work Phone Number ____________

Signature of Guardian (if patient is a dependent) ____________________ Relationship ____________________ Date ____________