# MEDICAL SERVICE QUESTIONNAIRE

**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:** ______________________

**Member Name:** ______________________ **Claim Number:** ______________________

**Member Number:** ______________________ **Date of Service:** ______________________

**We need your help to process claims correctly.** Please complete and return this form *within 10 days.* Without this information, claims payment may be delayed or denied. For *any* injury or medical condition, please answer the first four 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 1: CIRCUMSTANCES (Required)*

1. Briefly list the injuries or conditions, and describe the circumstances that caused the member to seek treatment:

2. Date when injury or condition happened or started:

3. Name, address, and phone number of insurance adjuster other than PacificSource (i.e. premise, homeowner, etc.)

4. Where did the accident or injury occur? ______________________

Was this a motor vehicle accident? ☐ Yes ☐ No *If yes, please complete Section 2.*

Did this happen on the job? ☐ Yes ☐ No *If yes, please complete Section 3.*

Other? ☐ Yes ☐ No Please describe: ______________________

4a. Has the member consulted an attorney?
☐ Yes ☐ No

4b. If yes, provide the attorney's name, address, and phone number:

*SECTION 2: INJURIES INVOLVING A MOTOR VEHICLE*

5. Was the member's auto at fault?
☐ Yes ☐ No

6. Member was *(please check all that apply)*: ☐ Other: ______________________

☐ In an automobile ☐ On a motorcycle ☐ A pedestrian or on a bicycle

☐ The driver ☐ A passenger ☐ Working on the auto

7. Was the member a passenger? ☐ Yes ☐ No

If yes, please provide the following information: Name of the vehicle owner:______________________

Owner's insurance company: ______________________ Name of adjuster:______________________

8. If another motor vehicle was involved, please provide the following:

Name and address of that vehicle's driver: ____________________________________________________________

________________________________________________________________________________________________

Name and address of insurance company covering that motor vehicle: _____________________________________

________________________________________________________________________________________________

Claim number:_______________ Name and phone number of adjuster: _____________________________________

9. Is the member an Oregon resident? ☐ Yes ☐ No

If no, does the member have personal injury protection (PIP) on their vehicle? ☐ Yes ☐ No

*SECTION 3: INJURIES OCCURRING ON THE JOB*

10. Did the injury or medical condition result from employment or while the member was working?

☐ Yes ☐ No *If yes, please complete questions 11 through 15.*

11. Please provide the employer's name and address.

12. Has the member reported this injury or medical condition to the employer? ☐ Yes ☐ No

13. Is the member self-employed? ☐ Yes ☐ No

14. Has a workers' compensation claim been filed? ☐ Yes ☐ No

Was the claim denied? ☐ Yes ☐ No *(attach copy of denial)*

If denied, does the member plan to appeal? ☐ Yes ☐ No

15. Please provide the following:

Claim number:________________________________

Name and address of employer's insurance carrier:_______________________________________________________

________________________________________________________________________________________________

Name and phone number of adjuster: _____________________________________________________________

**AUTHORIZATION TO REQUEST, RECEIVE, USE AND DISCLOSE PROTECTED HEALTH INFORMATION**

I hereby authorize PacificSource Health Plans ("PacificSource") to request, receive, use and/or disclose my protected health information relating to my accident or injury, including information about the benefits and medical service I received in connection with my accident or injury. My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

This authorization allows PacificSource to request and receive information related to my accident or from any and all third parties, including, but not limited to: hospitals, doctors' offices, other insurance companies, witnesses, and any other source of relevant information related to my claim. I further authorize PacificSource to request, receive, and/or review (as appropriate) any workers' compensations claims and/or files pertaining to my accident or injury for the purpose of ascertaining whether workers' compensation coverage is available for my accident or injury. This authorization will allow any third party to disclose information related to my accident or injury to PacificSource. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

By signing this authorization, I am specifically authorizing PacificSource to use and disclose my protected health information, as described above, to the following persons and/or entities:

- My attorney or other legal representative;
- My spouse;
- Any other insurance company providing coverage to me or another party to my accident or injury, as such coverage relates to my accident or injury; and
- An attorney representing any other party to my accident or injury.

***Optional***. I also authorize PacificSource to use and disclose my protected health information, as it relates to my accident or injury, to the following persons and/or entities (please fill in the blank with the names of those persons and/or entities): _

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

I certify that the information on this form is true and accurate to the best of my knowledge. I also certify that I understand that I may refuse to sign this authorization. I am aware that Workers' Compensation laws may require PacificSource Health Plans to disclose some, or all, of the foregoing information in accordance with state or federal law, or a valid subpoena, regardless of whether or not I sign this authorization.

*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 not completed, is revoked, or we receive a directive from any attorney hired by you to cease responding to third party claims for information, any claim relating to your accident or injury may be denied.**

| ______________________________ | ______________________________ | ______________ |
|---|---|---|
| **Member or Parent/Guardian Signature** | **PacificSource Member ID #** | **Date** |
| **Street Address** | **Home Phone Number** | |
| **City, State, and Zip** | **Work Phone Number** | |
| **Signature of Guardian (if patient is dependent)** | **Relationship** | **Date** |