BlueCross BlueShield of Western New York

A Division of HealthNow New York Inc. An Independent Licensee of the BlueCross BlueShield Association

Date	Patient's Name:	
Fax 1-716-887-7909	Identification #:	
Recipient Name & Address	Provider:	
	Date of Service:	
	Claim #:	
	Reference #:	
	Provider Office Accident Questionnaire/5300	

We Need Your Help!

We have received information regarding a possible accident or injury and request your help to determine if this patient is eligible to receive Workers' Compensation, No-Fault Automobile or Personal Liability insurance benefits. Please fill out Section I completely and all other appropriate sections of this form. We request that this form be returned within 5 days of receipt. **Failure to return this form may result in future claim denial.**

If you have any questions, please call 1-800-239-0443 and we will be glad to assist you.

I. **General Information**

Date of accident or injury: _____
Month Date Year

Brief description of physical injury(s): _____

Location of injury: _____

Check off the location/cause of the injury/accident:

- ☐ At work – Please proceed to Sections II, III and V
- ☐ Vehicle accident – Please proceed to Sections II, IV and V
- ☐ At home – Please proceed to Sections II and V
- ☐ Caused by another party – Please proceed to Sections II and V
- ☐ Other location – Please proceed to Sections II and V
- ☐ No accident – Please proceed to Section V

II. **Attorney Information**

Is an attorney involved? ☐ Yes ☐ No

If yes, please provide attorney's name, address and phone number below:

Identification #:

III. **Work Related** Workers' Compensation Board Case Number: _____

Name & Address of Patient's Employer	Name & Address of Workers' Compensation Carrier

A.	Is patient self-employed?	☐ Yes	☐ No
B.	Has the patient filed a Workers' Compensation claim?	☐ Yes	☐ No
C.	Was the Workers' Compensation claim denied? (If yes, **attach a copy** of the Notice of Decision.)	☐ Yes	☐ No
D.	If the claim was denied, is the patient appealing the decision?	☐ Yes	☐ No

IV. **Vehicle Related**

Type of Accident:

☐ Automobile

☐ Motorcycle

☐ Other, what type?

Name & Address of Patient's Insurance Carrier	Policy/Claim Number
	Phone number of carrier
	Representative handling the case

Was any other family member(s) involved in the accident?

☐ Yes ☐ No

If yes, please list family members. _____

If benefits have been denied, please attach a copy of the insurance carrier verification letter.

V. **Signature**

I have answered all questions truthfully and to the best of my knowledge.

Signature: _____

Date: _____ Daytime Phone: _____