Florida Blue

In the pursuit of health®

Florida's Blue Cross and Blue Shield Plan

You can send us your completed form by mail:

P.O. Box 45287, Jacksonville, FL 32232-9805

Or fax to: 1-904-997-5224

Member Name:	
Address:	
City, State, Zip	
Phone #:	
Contract #:	
Date of Accident:	Date of Service:

Dear Insured:

If you have recently experienced a claim related to an accident, you may use this form to furnish Florida Blue / Health Options, Inc. (HOI) information related to the claim. Your claim may have occurred due to a potential on the job injury/ illness or an automobile accident. Florida Blue/HOI works hard to keep health care costs down by making sure that when another insurance or other party is liable, they pay their share. Please help us to keep health care costs down by providing the information requested below. **Complete, sign, and return the questionnaire within 30 days. A prompt response will ensure accurate processing of future claims. You should mail the completed form to the address indicated above. Thank you.**

Was the claim indicated above related to an on the job injury/illness, automobile accident, or does another party have liability? ☐ Yes ☐ No

1. If the answer is No, please provide a brief description of what the claim was related to and complete Section A:
2. If the answer is Yes, please complete Section A and the Appropriate Section(s) B – D that follow, which pertains to the injury/illness or accident.

SECTION A:

To the best of my knowledge the information is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to Florida Blue/HOI all records necessary for processing claims filed by me or on my behalf.	
Date:	Subscriber's Signature:
Home Phone #:	Work Phone #:

SECTION B:

If your injury was auto-related, please complete this section and provide a copy of the accident report.

1. Date and location of your accident:
2. Has a claim been made to your auto insurance carrier? ☐ Yes ☐ No
3. Please provide the following information:
Name of Auto Insurance:
Mailing Address:
Phone Number:
Policy #:
Claim #:
4. Do you have a No-Fault deductible? ☐ Yes ☐ No
If Yes, please provide a copy of your automobile coverage limits.
5. Were you a guest passenger in another vehicle? ☐ Yes ☐ No

SECTION C:

If your injury/illness was job-related, please complete this section.

1. What was the initial date and cause of the injury/illness?
2. For what conditions were you treated?
3. Has a workers' compensation claim been filed by your employer? ☐ Yes ☐ No
If Yes, has the case been accepted or denied? ☐ Accepted ☐ Denied
Please provide documentation to support either decision and complete the following information:
Case or Claim #:
Carrier's Name:
Mailing Address:
Phone Number:
4. If you indicated that a workers' compensation claim was not filed by your employer please explain why, and provide any documents that you might have:
5. Are you self-employed? ☐ Yes ☐ No
If Yes, please provide the name of your workers' compensation carrier:

SECTION D:

If there is a possibility that another party may be responsible for your accident or injury/illness (potential lawsuit), please complete this section.

1. Date of accident or injury/illness:
2. Type of accident or injury/illness: ☐ Auto Accident ☐ Slip and Fall ☐ Malpractice
If none of the above, how did the injury occur?
3. Please provide the insurance information for the individual who caused the accident or injury/illness:
Name of Insurance Company:
Mailing Address:
Responsible Party:
Policy #:
4. Have you sought the assistance of an attorney? ☐ Yes ☐ No
If Yes, please provide the following:
Attorney's Name:
Mailing Address:
Phone Number: