Patient Information Form

for Other Party Liability (to be completed by Provider)

BlueCross BlueShield of Kansas

Section 1 – Member Information

CLEAR DATA

First Name _____ MI _____

Last Name _____

Member ID Number _____

Patient First Name _____ MI _____

Patient Last Name _____

Provider _____

Section 2 – Other Coverage Information

Annually, Blue Cross and Blue Shield of Kansas verifies whether or not your family has duplicate coverage. If it has been a year since your last visit to this provider, please answer the following:

Are you, your spouse or your covered dependent children enrolled in other insurance (medical, dental, vision or prescription – NOT Medicare, SRS/Medicaid)?
☐ Yes ☐ No

If you answered Yes, please complete all remaining questions in this section.

Policyholder First Name _____ MI _____

Policyholder Last Name _____

Policy Number _____

Name of Other Insurance Company _____

Address of Other Insurance Company _____

City _____

State _____ ZIP Code _____ Other Insurance Phone _____

Identification Number through which the policy is provided _____

Group Number through which the policy is provided (if applicable) _____

Employer or Group through which the policy is provided (if applicable) _____

Section 3 – Information About Injury

We also attempt to verify if injuries, carpel tunnel, heart attacks, hernias and back problems are eligible to be covered by worker's compensation or auto insurance. If your visit is related to an injury or one of the conditions described above, please answer the following questions *unless this is a follow-up visit and you have filled out this form previously.*

Date of Accident/Onset of Symptoms _____ _____ _____

Description of Injury (Body Part) or Condition _____

How did the injury or condition occur?

Where did the injury or condition occur?
☐ School ☐ Home ☐ Work
☐ Other _____

Was your accident or condition work related? ☐ Yes ☐ No

If Yes, are you self-employed? ☐ Yes ☐ No

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

If motorcycle, are you the owner? ☐ Yes ☐ No

If you are the owner, does your motorcycle insurance include coverage for medical expenses (Personal Injury Protection)? ☐ Yes ☐ No

Please continue on the next page.

Section 3 – Information About Injury (continued)

Was another party responsible for your injury or condition? ☐ Yes ☐ 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
Fax: (785) 290-0771

Online: bcbsks.com

By mail at: 1133 SW Topeka Blvd.
Mailstop 217E1
Topeka, KS 66629-0001