Providence
Health Plan

Providence Incident Questionnaire

Providence Health Plan has the right and the responsibility to our members to seek repayment for treatment when a third party, including another insurance company, is responsible. Please complete all sections of the form that apply to accident or injury.

Member name: _____

Date of birth: _____ Member ID #: _____

Phone number: _____

The treatment was due to one or more of the following (mark all that apply):

☐ Accident involving auto, motorcycle, ATV, boat or other motorized vehicle

☐ Occupational injury/Accident at work

☐ Product liability

☐ Medical malpractice

☐ Slip and fall on another person's property or business

☐ Injury at home – Do you own ☐ or rent ☐ the property?

☐ Illness or condition unrelated to an accident or injury (Chronic pain, arthritis, etc.)

☐ Other (Animal attack, injury at school, or other organized activities, etc.)

Have you filed a claim with anyone other than your health plan?

☐ Yes

☐ No

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Are you still treating for this injury/illness?

☐ Yes

☐ No

If no, what was the date of last treatment? _____

Provide details - list injury/injuries

_____

_____

_____

_____

If someone else is responsible for your injury/payment of your claims:

Location of injury: _____

Date of incident: _____

Did you file a claim? Yes ☐ No ☐

If yes, who did you file a claim against? _____

Claim #: _____

Insurance carrier's name: _____

Adjuster name: _____ Adjuster phone #: _____

Adjuster fax #: _____

Adjuster e-mail: _____

Insurance address: _____

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Motor vehicle accident

Number of vehicles in accident: _____

Are other people injured also members of your health plan? Yes ☐ No ☐

If yes, please list their names: _____

Was anyone else at fault? Yes ☐ No ☐

Did you file a claim? Yes ☐ No ☐

If yes, claim #: _____

Your automobile insurance information

Driver name: _____

Owner name: _____

Claim #: _____

Insurance carrier's name (of you or vehicle owner): _____

Adjuster name: _____ Adjuster phone #: _____

Adjuster fax #: _____

Adjuster e-mail: _____

Insurance address: _____

Does this policy carry Personal Injury Protection (PIP) or medical payment coverage?

Yes ☐ No ☐

Providence
Health Plan

Other driver(s) automobile insurance information

Other driver's name: _____

Other driver's auto insurance company: _____

Adjuster name: _____ Adjuster phone #: _____

Adjuster fax #: _____

Adjuster e-mail: _____

Insurance address: _____

Does this policy carry Personal Injury Protection (PIP) or medical payment coverage?

Yes ☐ No ☐

Workers' compensation claim

Did you file a workers' compensation claim? Yes ☐ No ☐

Claim #: _____

If yes, was your claim approved? Yes ☐ No ☐

If no, are you appealing the denial? Yes ☐ No ☐

Employer's name: _____

Employer's phone #: _____

Insurance company: _____

Claim #: _____

Adjuster name: _____ Adjuster phone #: _____

Adjuster fax #: _____

Adjuster e-mail: _____

Insurance address: _____

Providence
Health Plan

Attorney information (if applicable)

Your attorney's name: _____

Firm name: _____

Address: _____

City: _____ State: _____ Zip: _____

Attorney phone: _____ Attorney fax #: _____

Attorney E-Mail: _____

Settlement

If you filed a claim for any reason, did you receive a settlement? Yes ☐ No ☐

If yes, what was the date of the settlement? _____

Settlement amount? _____

Providence Health Plan

PLEASE READ AND SIGN BELOW

Your Providence health coverage includes a subrogation or a "right to recovery" provision. This provision helps us to control premium costs for all PHP members. It means that Providence Health Plan must be repaid for claims which are the result of an injury or accident and for which another party or insurance has paid or is paying. We may recover directly from you and/or the responsible party.

By my signature below, I give Providence Health Plan, and anyone acting on my behalf, authorization to request information about my accident, and the benefits and medical services I received in connection with my accident, from any persons who may be liable to me or my injured dependent and/or the insurance company that provides coverage for injuries related to this accident. I further authorize any such insurance company to release information to Providence Health Plan concerning my coverage and/or claim. If I have indicated that I am not filing a claim against anyone, but I do so after filling out this form, I will notify Providence Health Plan immediately by sending a registered letter to Providence Health Plan, Attn: Third Party Liability, PO Box 4327, Portland, OR 97208-4327.

I hereby agree and certify that all information given is correct to the best of my knowledge.

_____ _____

Signature Date

A signed copy of legal guardianship or power of attorney must accompany this form if not signed by the member.

If you have questions or concerns, please contact your Customer Service Team at **(503) 574-7500**, toll-free **(800) 878-4445**, or **TTY 711**, Monday through Friday, 8 a.m. to 5 p.m.

Return completed form:

Email: phpaccidentletter@providence.org with your member ID# in subject line

Mail: 3601 SW Murray Blvd. Beaverton, OR 97005 Attn:OFT

Fax: 503-574-8621