KAISER PERMANENTE®

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Kaiser Foundation Health Plan of Washington / Kaiser Foundation Health Plan of Washington Options, Inc. Incident Questionnaire

PO Box 210
5615 West Sunset Highway
Spokane, WA 99210-0210
Toll-free: 1-866-783-9594 or FAX: 509-241-7003

Our records indicate that services received by the patient named below appear to be related to an accident or injury. We have not declined any benefits at this time, but Kaiser Permanente is obligated to begin withholding benefits if this information is not received.

Please complete all sections of the form that apply to this accident or injury.

Name of injured:_____ Type of injury:_____

Address: _____ Kaiser Permanente Member #:_____

_____ Today's date :_____

City, State, Zip: _____

1. General information

Date of incident:_____ Time of incident:_____ am / pm Location of incident:_____

Injuries you received: (If not related to a specific incident, please describe what caused the onset of symptoms, sign and return this form in the enclosed envelope.)

_____

_____

Briefly describe the incident:_____

2. Complete this section for vehicle accident

Was the vehicle involved a: Car? ❑ Motorcycle? ❑ Other? _____

Was the patient a: Driver? ❑ Passenger? ❑ Pedestrian? ❑

Were any other members of your family injured in this accident?

Name:_____ Member #:_____ Injuries:_____

Name:_____ Member #:_____ Injuries:_____

Vehicle #1	**Vehicle #2**
Registered Owner:_____	Registered Owner:_____
Telephone #: (Hm)_____ (Wk)_____	Telephone #: (Hm)_____ (Wk)_____
Auto Ins. Co.:_____	Auto Ins. Co.:_____
Telephone #:_____	Telephone #:_____
Adjuster:_____	Adjuster:_____
Claim or Policy #:_____	Claim or Policy #:_____

Which vehicle was at fault? Vehicle #1 ❑ Vehicle #2 ❑

Which vehicle was the Kaiser Permanente enrollee riding in? Vehicle #1 ❑ Vehicle #2 ❑

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3. Complete this section for on the job injury or illness

Did this condition or injury occur on the job or as the result of employment? YES ❑ NO ❑

If no claim was filed, please explain why:_____

If yes, did you apply for Worker's Compensation Benefits? YES ❑ NO ❑

What was the claim number given?_____(Required)

Name of Employer:_____Phone #:_____

Address:_____

Is your employer self-insured or covered through the Department of Labor & Industries? Self Insured ❑ L&I ❑

4. Other accident or injury

Did this accident or injury occur on someone else's property? YES ❑ NO ❑

If yes, please provide the name and address of the legal owner of the property:

Name Address Telephone #

Do you intend to seek damages against the party responsible for this injury or condition YES ❑ NO ❑

Did you file a report with the property manager? YES ❑ NO ❑

Name Telephone #

5. Attorney information

Have you retained an attorney regarding legal protection for this accident or injury or illness? YES ❑ NO ❑

If yes, please provide the name & address of your attorney:

Name of Attorney Telephone #

Address (street, PO Box, etc.)

Your contract with Kaiser Permanente includes a subrogation provision. "Subrogation" means that if Kaiser Permanente provides any benefits on your behalf for injuries caused by another party who may be liable for those injuries, Kaiser Permanente is entitled to recover those costs from any settlement you receive from the at fault party. Your Kaiser Permanente contract also excludes coverage for benefits which would be payable under any personal injury protection, medpay, uninsured or underinsured motorist coverage, or workers compensation you may have. Therefore, Kaiser Permanente will also have the right to be reimbursed for any medical benefits from the proceeds of any personal injury protection, medpay, uninsured or underinsured motorist coverage, or workers compensation coverage's applicable to this incident.

Release of Information (must be signed)

I hereby authorize Kaiser Permanente to release any information about my accident or injury and the benefits and medical services I received in connection with my accident/injury. I authorize this release of information to any person who may be liable to me or to Kaiser Permanente, and to the insurance company of such person, or to any insurance company that provides coverage for the injuries related to this accident. I further authorize my vehicle or property insurance company to release any information concerning my coverage to Kaiser Permanente. *I certify that the information on this form is true and accurate to the best of my knowledge.*

Signed:_____Date:_____