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 ☐

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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: _______________________________________

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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? __________________

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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: PO Box 4327, Portland, OR 97208 Attn: OFT

Fax: 503-574-8621