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(405)841-9770

ACCIDENTAL INJURY QUESTIONNAIRE

COMPLETION OF THIS QUESTIONNAIRE BY THE INSURED WILL EXPEDITE THE PROCESSING OF RELATED CLAIMS

Subscriber ID#: _____

Patient Name (please print): _____

Date of Care: _____

Physician Name: _____

In order to make a benefit determination, we must have the following information from the insured:

1. Is this care related to an accident injury? Yes No
If yes, is this a new injury or a previous injury? _____
2. If this was a previous injury, please provide the name and address of the attending physician providing treatment for the previous injury.
Physician's name: _____
Address: _____
3. What date did the new injury occur? (Month/Day/Year) _____
4. What type of new injury is this? Auto Motorcycle Work-related
 Interscholastic sports Other (Please describe) _____
5. Where did the new injury occur? _____

6. How did the new injury occur? _____

7. Is another person or organization responsible for this new injury? Yes No

I hereby certify that my answers are complete and accurate.

[Reminder: It is a violation of Oklahoma State Law to give false information to an insurance company.]

Patient Signature: _____ Date: _____

For Physician's office use only:

Return this completed form to Blue Cross and Blue Shield of Oklahoma – Attn: Supervisor, WC;
PO Bos 3283; Tulsa, OK 74104-3283 or fax to: (918) 560-7865-Atten Supervisor, WC.

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