

# Patient Questionnaire

This is a form to be used in filing your provider's statement with Blue Cross of Idaho Health Service, Inc. To use this form:

1. Complete the **PATIENT AND ENROLLEE INFORMATION** section below:
2. If any of the services were related to an accident, you must also complete the **ACCIDENTAL INJURY INFORMATION** section below.
3. Circle the charges on your provider's statement that you want us to handle, and staple the statement to this form. The provider's statement **must** show, for **each** service: a procedure code or description of the service, the date it was furnished, and the charge for the service. **Use a separate form for each provider who has billed you.**
4. To file charges for more than one patient, even if the charges are all on one billing, please:
  - Complete a separate form for each patient AND
  - Attach a separate copy of the provider's billing to each patient's form.
5. Mail all forms to: Blue Cross of Idaho Health Service, Inc.  
Box 7408  
Boise, Idaho 83707

**You should hear from us in about three weeks or less. Please do not re-submit these charges to us in the meantime.**

PATIENT AND ENROLLEE INFORMATION			
Patient's Name (First Name, Middle Initial, Last Name)		Patient's Date of Birth	Enrollee's Name (First Name, Middle Initial, Last Name)
Do you or any of your dependents have other Health coverage? (This includes other Blue Cross and Blue Shield coverage as well as Medicare.) <input type="checkbox"/> YES <input type="checkbox"/> NO		Patient's Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Enrollee's Blue Cross Identification Number
Type of Coverage If Medicare <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Part A <input type="checkbox"/> Part B		Patient's Relationship to Enrollee <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Enrollee's Group No. (or Program Number)
Coverage is for (Check all applicable boxes) <input type="checkbox"/> Enrollee <input type="checkbox"/> Spouse <input type="checkbox"/> Children		Name and Address of Other Carrier	Enrollee's Address (Street, City, State, Zip Code)
Name and Address of Other Carrier		ID Number with Other Carrier	
Name and Address of Other Carrier		Group Number/Name with Other Carrier	
Was this condition the result of an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO ▶ If NO, sign at the bottom and return the form to us.		Effective Date with Other Carrier	
ACCIDENTAL INJURY INFORMATION (Please complete if claim is related to an injury)			
Date of Injury	Describe how and where the injury occurred		
To your knowledge, who was responsible for the accident?	Have you received settlement from the responsible party? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you intend to make a claim against the responsible party? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> POSSIBLY	
Was the condition the result of an auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Was this injury or illness sustained while performing work required by the patient's employment? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Is the patient covered by Workers' compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is the patient self employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the patient filed a claim with the Industrial Accident Commission? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the patient notified his, or her employer of this condition? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is the patient covered by a liability coverage other than Workers' Compensation for work-incurred injuries? <input type="checkbox"/> YES <input type="checkbox"/> NO		Has the patient filed a claim with his or her employer's liability coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Authorized Signature of Enrollee	Make Payment to <input type="checkbox"/> Enrollee (Attach proof of payment) <input type="checkbox"/> Provider	Date Submitted	

**WARNING:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony. In cases of proven fraud, Blue Cross of Idaho will terminate agreements for services and benefits, seek restitution of dollars lost, and pursue criminal prosecution to the full extent of the law.