ASURIS NORTHWEST HEALTH

Asuris Northwest Health
528 East Spokane Falls Boulevard
Suite 301
Spokane, WA 99202
1 (888) 367-2109

Please return the completed form.
By Mail: PO Box 12625 MS S1C
Salem, OR 97309
By Fax: 1 (888) 891-0771

Today's Date: (mm/dd/yyyy)
ID Number:
Patient:
Claim Number:
Provider:
Date of Service: (mm/dd/yyyy)
Client Letter ID:

Incident Report

Please complete this Incident Report and return it in the enclosed envelope within 45 days of receipt. If we do not receive your complete and signed Incident Report within forty-five days, all claims related to this incident will be denied until the Incident Report is received. Please be aware that if claims are denied due to tardiness in returning your completed Incident Report, charges billed by your provider will be considered your responsibility and the provider may bill you directly for these expenses.

Complete information is essential and very much appreciated. When additional information is required, claims cannot be processed. It will take up to 15 days after we receive all necessary information before claims can be processed. To avoid delays, carefully and completely provide all requested information.

GENERAL INFORMATION

Briefly explain why you sought treatment. Please identify the specific body area(s) affected by this injury, if applicable. How did the injury occur? What was injured? Where did the event occur?

Date of injury or onset of illness (mm/dd/yyyy)_____ Explanation_____

Was the service received for the injury described above related to an incident that occurred:

- ☐ At work or on the job; or
- ☐ Due to an auto accident or auto-related injury; or
- ☐ Due to an Other Vehicle Accident (motorcycle, scooter, snowmobile, boat, etc. accident); or
- ☐ Caused by another party; or
- ☐ Caused by something/someone at a business or residence other than your own home?

The service received from the injury described above:

- ☐ Was not incurred at work or on the job; or
- ☐ Was not caused by another party or incurred as the result of an accident; or
- ☐ No other person was involved. Please explain above.

If the injuries you sustained were not related to an accident or incurred at work or on the job, please skip to the end of this form and sign, date and return it to us.

Otherwise, please continue on and complete the applicable section(s) on pages 2 and 3, then sign, date and return the form.

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GENERAL INFORMATION (continued)

Do you intend to seek recovery for damages from the party responsible for the accident, injury or work-related condition? ☐ **Yes** ☐ **No**

Have you been offered a settlement? ☐ Yes ☐ No
Have you accepted a settlement? ☐ Yes ☐ No

If Yes, date of settlement (mm/dd/yyyy) _____ Amount of settlement _____

Please include a copy of your settlement documents

Have you hired an attorney? ☐ **Yes** ☐ **No**

Attorney's Name _____ Phone Number (xxx) xxx-xxxx _____

Attorney's Address _____

Was the treatment a result of an auto/other type of vehicle injury/accident?
☐ **Yes (please give details below)** ☐ **No**

The patient was a: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other
The vehicle was a: ☐ Car ☐ Motorcycle ☐ ATV ☐ Snowmobile ☐ Other

Were there more than two vehicles involved? ☐ Yes ☐ No

Name of the At-Fault Party _____

At-Fault Party's Insurance Company _____

At-Fault Party's Insurance Company's Address _____

_____

Adjuster's Name _____ Adjuster's Phone Number (xxx) xxx-xxxx _____

Claim Number _____ Adjuster's E-mail Address Email address _____

Do you have vehicle insurance? ☐ Yes ☐ No *If No, attach a copy of police report.

Is there Personal Injury Protection (PIP) or Medical Payments (Med-Pay) under your vehicle insurance?

☐ **Yes** ☐ **No** Please attach a photocopy of your insurance policy declaration page that shows what types of coverage you have (in particular, whether your policy provides PIP or Med-Pay coverage) and the monetary amount of your coverage.

Name of your Insurance Company _____

Insurance Company's Address _____

Adjuster's Name _____ Adjuster's Phone Number (xxx) xxx-xxxx _____

Claim Number _____ Adjuster's E-mail Address Email address _____

Name of other family member(s) covered on your health plan that were injured _____

_____

GENERAL INFORMATION (continued)

If accident was not in your own vehicle, name and address of owner of vehicle in which patient was traveling.

Insurance Company, Claim Number, Adjuster's Name and Phone Number for vehicle in which patient was traveling.

Did this vehicle policy have PIP or Med-Pay benefits for passengers? ☐ Yes ☐ No

***If PIP/Med-Pay is exhausted, please provide copy of auto insurance payment ledger.**

WORK-RELATED CONDITION

Was the service you received necessitated by an injury, condition, or illness caused or received at work or on the job? ☐ Yes ☐ No

If Yes, please tell us what happened

When (or over what period of time) did you incur your injury or illness

Have you filed a claim with Workers' Compensation? ☐ Yes ☐ No

If Yes, please provide: Claim Number

Workers' Compensation Carrier Name, Address

Adjuster's Name Adjuster's Phone Number (xxx) xxx-xxxx

***If your claim was denied or closed, please attach a copy of your closure notice or denial.**

Do you plan to appeal this decision? ☐ Yes ☐ No

Are you self-employed? ☐ Yes ☐ No

If Yes, do you carry an industrial policy for yourself? ☐ Yes ☐ No

Name and Address of Industrial carrier (if applicable)

Are you a police officer or firefighter under LEOFF-1? ☐ Yes ☐ No

OTHER ACCIDENT OR INJURY

Did the accident or injury occur on someone else's property? ☐ Yes ☐ No

Do the property owners have insurance to cover medical expenses? ☐ Yes ☐ No

Do you intend to file a claim? ☐ Yes ☐ No

If Yes, please provide the name of the insurance company

Adjuster's Name Claim Number

Address Phone Number (xxx) xxx-xxxx

SUBSCRIBER'S STATEMENTS

I understand that if I, or any of my covered dependents ("Subscriber") have been in an accident or have been injured by another party, or have work-related condition, the benefits of my health benefit plan will be available to me or my covered dependents, subject to the terms, limitations, and exclusions of the plan. The Subscriber further understands that, as a condition of coverage, the health benefit plan requires the Subscriber to cooperate with Asuris Northwest Health (Asuris) in its efforts to recover the cost of benefits it has provided from the responsible party or the responsible party's insurer, and that if the Subscriber does not cooperate in full accordance with the health benefit plan, that Asuris may pursue reimbursement from the responsible party, or the responsible party's insurer, or from the Subscriber in accordance with the health benefit plan and applicable law.

The Subscriber understands that Asuris and anyone acting on its behalf is permitted by law to release information about any accident, injury, or work-related condition described on this Incident Report and the benefits and medical service the Subscriber received in connection with that accident, injury, or work-related condition to any potentially responsible party and the potentially responsible parties' insurer.

The Subscriber authorizes the insurance company(ies) listed on pages 2 and 3 to release any information concerning the Subscriber's coverage to Asuris. The Subscriber further authorizes Asuris to review the Subscriber's workers' compensation claims files pertaining to this Incident Report so that Asuris can determine whether workers' compensation coverage is available for any potential work-related condition.

The Subscriber understands that it is a crime to knowingly provide false, misleading, or incomplete information to Asuris with the intent of defrauding the company, and that the penalties for committing fraud include imprisonment, fines and denial of insurance benefits. Moreover, Asuris will have the right to pursue its legal rights, including the collection of claims payments and any other damages.

The Subscriber accordingly declares that the information on pages 1 through 3 is true, correct and complete.

DATED and SIGNED on the _____ **day of** _____ **, 20**_____ **.**

Home Phone Number (xxx) xxx-xxxx _____ Work Phone Number (xxx) xxx-xxxx _____

Cell Phone Number (xxx) xxx-xxxx _____ E-mail Address Email address _____

Subscriber's Signature ▶ _____

Date (mm/dd/yyyy) _____ ID Number _____

Injured Dependent/Guardian Signature ▶ _____

Date (mm/dd/yyyy) _____ Relationship _____

We may need to contact you further to clarify your answers or obtain additional information. Please include available times if there are time restrictions regarding when we should contact you. Also, please include your e-mail address if it's okay to contact you in that manner.

Additional information/clarification _____

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