Medical Service Questionnaire

PacificSource HEALTH PLANS

Phone: **541-684-5587** | Fax: 541-225-3633
Email: ThirdParty@PacificSource.com | Address: PO Box 7068, Springfield, OR 97475

Date sent _____ Body part _____ Date of service _____

Member name _____ Claim number _____ Member ID _____

Section 1: Circumstances (required)

1. Briefly list the injuries or conditions and describe the circumstances that caused you to seek treatment:

   _____

   _____

   _____

   _____

2. Date when injury/condition happened or started: _____

3. Name, address, and phone of other insurance company if someone else is responsible:

   _____

   _____

4. Where did the accident/injury occur? _____

   Was this a motor vehicle accident? ☐ Yes ☐ No (If "yes," please complete Section 2.)

   Did this happen on the job? ☐ Yes ☐ No (If "yes," please complete Section 3.)

   Other? Please describe: _____

   _____

   _____

5. Have you consulted an attorney? ☐ Yes ☐ No

   If "yes," please provide attorney's name, address, and phone:

   _____

   _____

   _____

   _____

Section 2: Injuries involving a motor vehicle

6. Was your vehicle at fault? ☐ Yes ☐ No
7. I was (check all that apply): ☐ In a vehicle ☐ On a motorcycle ☐ A pedestrian or on a bicycle ☐ The driver ☐ A passenger ☐ Working on the vehicle ☐ Other: _____
8. If another vehicle was involved, please provide the following:

   Name and address of that vehicle's driver: _____

   _____

   Name and address of insurance company covering that vehicle: _____

   _____

   Claim number: _____

   Name and phone number of adjuster: _____
9. Do you carry personal injury protection (PIP) or first party auto medical payment coverage on your vehicle?

   ☐ Yes ☐ No

Section 3: Injuries occurring on the job

10. Did the injury or medical condition result from employment or while you were working? ☐ Yes ☐ No

    (If "yes," please complete questions 11–15.)
11. Employer's name and address: _____

    _____

    _____
12. Have you reported this injury or medical condition to your employer? ☐ Yes ☐ No
13. Are you self-employed? ☐ Yes ☐ No
14. Has a workers' compensation claim been filed? ☐ Yes ☐ No

    Was the claim denied? ☐ Yes ☐ No (If "yes," please attach a copy of denial.)

    If denied, do you plan to appeal? ☐ Yes ☐ No
15. Claim number: _____

    Name and address of employer's insurance carrier: _____

    _____

    Name and phone number of adjuster: _____

    _____

Section 4: Authorization to request, receive, use, and disclose protected health information

I hereby authorize PacificSource Health Plans ("PacificSource") to request, receive, use, and/or disclose my protected health information relating to my accident or injury, including information about the benefits and medical service I received in connection with my accident or injury. My protected health information includes medical records, emergency and urgent care records, billing statements, diagnostic imaging reports, transcribed hospital reports, clinical office chart notes, laboratory reports, dental records, pathology reports, physical therapy records, hospital records (including nursing records and progress notes), and any personal or medical information related to the purpose of this authorization.

This authorization allows PacificSource to request and receive information related to my accident or from any and all third parties, including, but not limited to, hospitals, doctors' offices, other insurance companies, witnesses, and any other source of relevant information related to my claim. I further authorize PacificSource to request, receive, and/or review (as appropriate) any workers' compensations claims and/or files pertaining to my accident or injury for the purpose of ascertaining whether workers' compensation coverage is available for my accident or injury. This authorization will allow any third party to disclose information related to my accident or injury to PacificSource. Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum necessary information to achieve that purpose.

By signing this authorization, I am specifically authorizing PacificSource to use and disclose my protected health information, as described above, to the following persons and/or entities:

- My attorney or other legal representative
- My spouse
- Any other insurance company providing coverage to me or another party to my accident or injury, as such coverage relates to my accident or injury
- An attorney representing any other party to my accident or injury

Optional. I also authorize PacificSource to use and disclose my protected health information, as it relates to my accident or injury, to the following persons and/or entities (please complete with the names of those persons and/or entities):

_____

_____

_____

I certify that the information on this form is true and accurate to the best of my knowledge. I also certify that I understand that I may refuse to sign this authorization. I'm aware that workers' compensation laws may require PacificSource Health Plans to disclose some or all of the foregoing information in accordance with state or federal law, or a valid subpoena, regardless of whether or not I sign this authorization.

I have the right to revoke this authorization in writing at any time. If I revoke my authorization, the information will no longer be used or disclosed for the reasons covered by this written authorization. Any uses or disclosures already made with my permission cannot be taken back. Unless revoked, this authorization will be in force until the purpose of this authorization has been completed, but not longer than 24 months.

Member or parent/guardian signature _____

PacificSource member ID _____ Date _____

Street address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

If patient is dependent, relationship _____

Please note: If this authorization is not completed, is revoked, or we receive a directive from any attorney hired by you to cease responding to third party claims for information, any claim relating to your accident or injury may be denied.

To revoke this authorization, send a written statement that you are revoking this authorization to PacificSource Health Plans, PO Box 7068, Springfield, OR 97475.