Claim Form

(A claim shall be presented by the claimant or by a person acting on his behalf.)

NAME OF DISTRICT:

1

Claimant name, address (**mailing** address if different), phone number, social security number, e-mail address, and date of birth.

*Effective January 1, 2010, the Medicare Secondary Payer Act (Federal Law) requires the District/Agency to report all claims involving payments for bodily injury and/or medical treatments to Medicare. As such, if you are seeking **medical damages**, we **MUST** have both your Social Security Number and your date of birth.*

Name:	Phone Number:
Address(es):	Social Security No.:
	Date of Birth:
	E-mail:

2

List name, address, and phone number of any witnesses.

Name:

Address:

Phone Number:

3

List the **date, time, place,** and **other circumstances** of the occurrence or transaction, which gave rise to the claim asserted.

Date: Time: Place:

Tell What Happened (give complete information):

NOTE: Attach any photographs you may have regarding this claim.

4

Give a general description of the indebtedness, obligation, injury, damage, or loss incurred so far as it may be known at the time of presentation of the claim.

5

Give the name or names of the public employee or employees causing the injury, damage, or loss, if known.

6

The amount claimed if it totals less than ten thousand dollars ($10,000) as of the date of presentation of the claim, including the estimated amount of any prospective injury, damage or loss, insofar as it may be known at the time of the presentation of the claim, together with the basis of computation of the amount claimed. If the amount claimed exceeds ten thousand dollars ($10,000), no dollar amount shall be included in the claim. However, it shall indicate whether the claim would be a limited civil case.

Date: Time: Signature:

ANSWER ALL QUESTIONS. OMITTING INFORMATION COULD MAKE YOUR CLAIM LEGALLY INSUFFICIENT!