COVERYS

NOTIFICATION OF CLAIM OR POTENTIAL CLAIM FORM

Insured information

Named Insured: Policy #, if known:

Address:

Contact Person: Phone Number:

Email Address:

Other insurance, if applicable:

Other involved insureds:

Reason for Notification

☐ Potential Claim ☐ Formal Claim/Claim Letter ☐ Notice of Intent ☐ Summons & Complaint

☐ Medical Payments ☐ 180 day Letter Other_____

Patient / Claimant Information

Name of patient/claimant: _____

(First) (MI) (Last)

Address:_____ Telephone:_____

_____ Date of birth:_____

_____

Contact person for claimant: _____

Occurrence Information

Date of incident (if unknown, give treatment dates):

_____

Description of incident or treatment:

_____

_____

_____

_____

Injuries (if known): _____

_____

_____

Other significant information: _____

_____

Report completed by: _____ Date:_____

Phone number: _____ Email: _____

Please mail, fax or email this page to:
22443 SE 240th St., Ste. 102, Maple Valley, WA 98038 Fax: 425.310.7210
Tel: 800.772.1201 | Email: claimlossinfowcc@coverys.com

Medical Professional Mutual Insurance Company, ProSelect® Insurance Company, and Coverys Specialty Insurance Company.
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