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:_______________________

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Contact person for claimant: ____

Occurrence Information

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

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Description of incident or treatment:

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____

Injuries (if known): ____

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Other significant information: ____

____

Report completed by: ________________________ Date:____________________________

Phone number: ___________________________ Email: _________________________

Please fax or email this page to:

Fax: 973.993.1227 | Email: Claimlossinfonj@coverys.com

Tel: 888.993.8580