COVERYS

NOTIFICATION OF CLAIM OR POTENTIAL CLAIM FORM

Insured information

Name 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 | Tel: 800.772.1201 | Fax: 425.310.7210

claimlossinfowcc@coverys.com