

University of Washington Claim Form

In order to file a claim, return completed form to: Office of Risk Management
Box 351276
Seattle, WA 98195
(206) 543-3657 Fax: (206) 543-3773
Website: <http://f2.washington.edu/treasury/riskmgmt/home>

In the event that the claim cannot be resolved informally, filing this claim with the University of Washington does not constitute a filing with the Department of Enterprise Services pursuant to RCW 4.92.110.

Claimant's Name/Names (Person alleging damages): _____

Claimant's Date of Birth: _____

Claimant's Home Telephone Number: _____

Claimant's Business Telephone Number: _____

Claimant's Email Address: _____

Mailing Address: _____

Residence Address (if different): _____

Department allegedly responsible for damage/injury: _____

Total amount of damages claimed: _____

Give itemization of damages for total amount claimed: _____

Date of incident: _____ Time: _____

Location of incident: _____

Name, address, and telephone number of treating physician (attach medical reports and billings):

I/We submit that I/we have read the foregoing and submit that the information contained therein is true and correct to the best of my/our knowledge.

1st Claimant's signature: _____ Date: _____

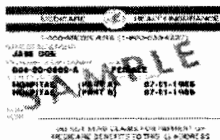
2nd Claimant's signature: _____ Date: _____

MMSEA REPORTING COMPLIANCE DECLARATION

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary and recover after the insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers like the state of Washington), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly. Please answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.



Section I

Are you presently, or have you ever been enrolled in Medicare Part A or Part B?	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
<i>If yes, please complete the following. If no, proceed to Section II.</i>						
Full Name: (Please print the name exactly as it appears on the SSN or Medicare card if available.)						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Medicare Claim Number:</td> <td style="width: 45%;"></td> <td style="width: 20%;">Date of Birth (Mo/Day/Year)</td> <td style="width: 20%;"></td> </tr> </table>			Medicare Claim Number:		Date of Birth (Mo/Day/Year)	
Medicare Claim Number:		Date of Birth (Mo/Day/Year)				
Social Security Number: (If Medicare Claim Number is Unavailable)		Sex Female <input type="checkbox"/> Male <input type="checkbox"/>				

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) _____
Claim Number

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form _____
Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

Claimant Name (Please Print) _____
Claim Number

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

Signature of Person Completing This Form _____
Date