



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:
3100 West Rd., Bldg 1, East Lansing, MI 48823
Tel: 1.800.313.5888 | Email: claimlossinfomi@coverys.com