COVERYS NOTIFICATION OF CLAIM OR POTENTIAL CLAIM FORM

Insured information

Name Insured: Policy #, if known:

Address: Account/refer #:

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 email, mail, or fax this page to: **claimlossinfonj@coverys.com**

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