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:
One Financial Center, Boston, MA 02111 Fax: 617.428.9805
Tel: 800.225.6168 | Email: claimlossinfo@coverys.com