

DEPARTMENT OF LAW

CLAIM FORM



Claim Type: (A). Vehicle damage
 (B). Property damage (not vehicle)
 (C). Personal injury (2-page Medicare/Medicaid form must be submitted with your claim form)
 (D). Other
Claims cannot be paid without supporting documentation

GENERAL INFORMATION (THIS SECTION MUST BE COMPLETED).

Claimant Name: _____ Date of Birth: _____

Complete Address: _____

Phone No(s): (____) _____ /c_(____) _____

Last Four (4) Social Security Nos: XXX-XX-_____

Incident date: _____ Incident location: _____

Briefly explain what happened: _____

Name/address/phone of any witnesses, if any: _____

(A). ONLY FILL OUT SECTION (A) IF YOU HAVE SUSTAINED VEHICLE DAMAGE.

Was a police report filed? yes no If yes, Incident Report Number: _____
 If no, please state why not _____

Ambulance called? yes no

Were you taken to the hospital? yes no If yes, list the hospital/address/phone: _____

Was a Doctor consulted? yes no If yes, list doctor's name/address/phone: _____

Do you have medical insurance/Medicare/Medicaid? yes no If yes, list type and policy
 (Note: you must attach a completed copy of the 2-page Medicare/Medicaid form if
 applicable)._____

Has the vehicle been registered with the Michigan Secretary of State? yes no. If yes, **please attach proof of registration to this claim form.**

Do you have auto insurance? yes no If yes, **please attach proof of insurance to this claim form.**

Did you file a claim with your insurance company for this event? yes no If yes, was your claim approved or denied? _____

Are you the owner of the vehicle involved in the auto accident? yes no If no, list the vehicle owner's name/address/phone: _____

Describe the injuries/damages sustained and amount of damages being claimed. **Please attach 2 estimates. Claims cannot be paid without supporting documentation.**

(B). ONLY FILL OUT SECTION (B) IF YOU HAVE SUSTAINED PROPERTY DAMAGE (NOT VEHICLE).

Are you the property owner? yes no If no, list the name/address/phone of the property owner: _____

Are you a tenant leasing or renting the property? yes no

Do you have homeowner's/renter's insurance? yes no If yes, list name and policy number: _____

Did you file a claim with your insurance company for this event? yes no If yes, was your claim approved or denied? _____

Describe the damages sustained and amount of damages being claimed (Note: prior to the item(s) being inspected by the City, please take pictures of all damaged items and only discard items that may cause a health risk). To support the damage claim amount, **please attach invoices, estimates, and receipts. Claims cannot be paid without supporting documentation.** _____

(C) ONLY FILL OUT SECTION (C) IF YOU HAVE SUSTAINED PERSONAL INJURY.

Was a police report filed? yes no If yes, Incident Report Number: _____

If no, please state why not _____

Ambulance called? yes no

Were you taken to the hospital? yes no If yes, list the hospital/address/phone: _____

Was a Doctor consulted? yes no If yes, list doctor's name/address/phone: _____

Do you have medical insurance/Medicare/Medicaid? yes no If yes, list type and policy (Note: you must attach a completed copy of the 2-page Medicare/Medicaid form if applicable). _____

Did you file a claim with your insurance company for this event? yes no If yes, was your claim approved or denied? _____

Describe the injuries sustained and amount of damages being claimed. **Please attach invoices, estimates, and receipts. Claims cannot be paid without supporting documentation.**

(D) ONLY FILL OUT SECTION (D) IF NO OTHER SECTION IS APPLICABLE.

Was a police report filed? yes no If yes, Incident Report Number: _____

If no, please state why not _____

Please describe the injuries/damages sustained and amount of damages being claimed.
Please attach invoices, estimates, and receipts. *Claims cannot be paid without supporting documentation.*

Please briefly list any other information not provided for in the above sections that you think will aid the City in processing your claim. _____

I (CLAIMANT) DECLARE UNDER THE PENALTY OF PERJURY THAT THE FACTS STATED IN THE ATTACHED DOCUMENT ARE TRUE TO THE BEST OF MY KNOWLEDGE. I FURTHER ACKNOWLEDGE THAT BY AFFIXING MY SIGNATURE TO THIS FORM THAT I HAVE NOT CAUSED A CLAIM TO BE FILED FOR ANY IMPROPER PURPOSE.

Signature of Claimant

Dated: _____

RETURN FORM AND ATTACHMENTS TO:
City of Dearborn, Department of Law
16901 Michigan Avenue, Suite 14, Dearborn, Michigan 48126-2729
(313) 943-2035 • FAX (313) 943-2469

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 other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), 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.

We are asking you to 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?															<input type="checkbox"/> Yes		<input type="checkbox"/> No																					
<i>If yes, please complete the following. If no, proceed to Section II.</i>																																						
Full Name: <i>(Please print the name exactly as it appears on your SSN or Medicare card if available.)</i>																																						
<table border="1" style="width:100%; height:20px;"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																																						
Medicare Claim Number:										Date of Birth (Mo/Day/Year)																												
Social Security Number: <i>(If Medicare Claim Number is Unavailable)</i>												Sex		<input type="checkbox"/> Female		<input type="checkbox"/> Male																						

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