University of Washington Claim Form

To file a claim with UW Claim Services, complete this form and submit:

(Preferred)
By email to: claims@uw.edu

OR
By fax to: (206) 543-6744

OR
By mail to: Claim Services
Box 354964
Seattle, WA 98195

Note: Claim Services will primarily communicate by email. Please notify us if you cannot access email.

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. This claim form is subject to public disclosure, and may be disclosed without redaction.

UW complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. If you have limited English proficiency, please see page 4.

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: ____

____

University of Washington Claim Form

Names, addresses, and telephone numbers of all persons involved in/or otherwise witness to this incident:

____

____

____

____

Names and telephone numbers of University employees having knowledge about this incident:

____

____

____

Describe circumstances causing injury or damages (attach extra pages if necessary):

____

____

____

____

____

____

____

____

____

____

____

____

____

____

University of Washington Claim Form

If applicable, please provide 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: ________________

University of Washington Claim Form

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-206-598-4425 (TTY: 1-206-598-4002).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-206-598-4425 (TTY: 1-206-598-4002).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-206-598-4425 (TTY: 1-206-598-4002).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-206-598-4425 (TTY: 1-206-598-4002).번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-206-598-4425 (TTY: 1-206-598-4002).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-206-598-4425 (телетайп: 1-206-598-4002).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-206-598-4425.1-xxx-xxx-xxxx (телетайп: 1-206-598-4002).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-206-598-4425 (TTY: 1-206-598-4002).។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-206-598-4425 (TTY: 1-206-598-4002).まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-206-598-4425 (መስማት ለተሳናቸው: 1-206-598-4002).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 206-598-4425-(رقم
هاتف الصم والبكم: 206-598-4002).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-206-598-4425 (TTY: 1-206-598-4002). 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-206-598-4425 (TTY: 1-206-598-4002).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-206-598-4425 (TTY: 1-206-598-4002).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-206-598-4425 (TTY: 1-206-598-4002).

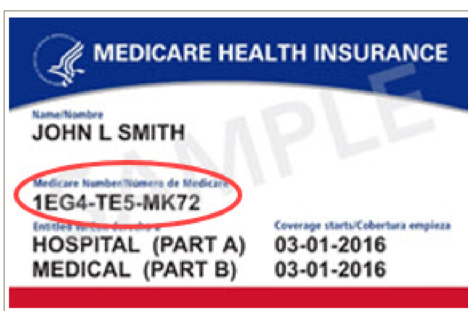
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a “conditional payment” so as to not inconvenience the beneficiary, and then recover after the other 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), no-fault insurers, and workers’ compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to help CMS to properly coordinate payment of benefits among plans so that your medical 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.

Please note the Medicare Number located on this card.



Section I

Are you presently, or have you ever been, enrolled in Medicare?	☐ Yes	☐ No
If yes, please complete the following. If no, proceed to Section II.		
***Full Name:** (Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Number:	**Date of Birth (Mo/Day/Year)** / /	
****Social Security Number:** (If Medicare Number is Unavailable) - -	**Sex** ☐ Female	☐ Male

** Note: If you are unable to provide your Medicare Number **and** uncomfortable with providing your full Social Security Number (SSN), you have the option to provide the last **5** digits of your SSN in the section above.

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)

____

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)

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**