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: ________________________________________________________________________________
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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):

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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: _______________________
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注意：如果您使用 Bristolian Chinese, you can use free language assistance services. Please call 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。

Remark: If you speak Arabic, you can use free language services. Please call 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.

![Medicare Card](image)

**Section I**

<table>
<thead>
<tr>
<th>Are you presently, or have you ever been, enrolled in Medicare?</th>
<th>□ Yes</th>
<th>□ No</th>
</tr>
</thead>
</table>

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:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Date of Birth (Mo/Day/Year)</th>
<th></th>
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</thead>
</table>

**Social Security Number:**

(If Medicare Number is Unavailable)

<table>
<thead>
<tr>
<th></th>
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<th>Sex</th>
<th>□ Female</th>
<th>□ Male</th>
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</thead>
</table>

** 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 __________________________