

# 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](mailto:claims@uw.edu)

OR

By fax to: (206) 543-6744

OR

By mail to: Claim Services

Box 354964

Seattle, WA 98105

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:

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

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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):

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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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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 (телефон: 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 (телефайп: 1-206-598-4002).

ប្រយោជន៍: បេសិនធម្មកនិយាយ ភាសាខ្មែរ, សេវាចំនួយផ្លូវការភាសា យោយមិនគិតឈ្មោះ គឺអាជមានសំបែបនៃការ ចូរទៅសង្គម 1-206-598-4425 (TTY: 1-206-598-4002).<sup>4</sup>

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: የሚገኘውን ቁጥር አማራር ከዚህ የተረጋገጠው እርምጃ ይረዳች ይችላል፡፡ በላይ ላይገባዎች ተዘጋጀች፡ ወደ ማኅተለው ቁጥር ፩/የጥፊት 1-206-598-4425 (መስማት ለተዘጋጀዎች: 1-206-598-4002)

4425-598-206 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم- (رقم 4002-598-206 لاقى المصہ و المکہ):

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-206-598-4425 (TTY: 1-206-598-1002) 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).

ໃບດາວກ: ຖ້າວ່າ ທ່ານວ່າພາສາ ລາວ, ການປໍ່ວົງການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍປ່ານັ້ນ, ແມ່ນມີຜົມໃຫ້ທ່ານ. ໂທດ 1-206-598-4425 (TTV: 1-206-598-4002)

XIYYEEFFA NAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-206 598 4425 (TTX: 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?                                     |  |  |  |  |  |  |  |  |  |  |  | <input type="checkbox"/> Yes   | <input type="checkbox"/> 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<br>(Mo/Day/Year) |                                 |                               |
|   |  |  |  |  |  |  |  |  |  |  |  | /                              | /                               |                               |
| **Social Security Number:<br>(If Medicare Number is Unavailable)                                    |  |  |  |  |  |  |  |  |  |  |  | Sex                            | <input type="checkbox"/> Female | <input type="checkbox"/> 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.

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**Claimant Name (Please Print)**

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**Name of Person Completing This Form If Claimant is Unable (Please Print)**

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**Signature of Person Completing This Form**

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**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

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**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:**

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**Signature of Person Completing This Form**

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**Date**