Utah Transit Authority
Claims Unit

Date:

# Procedure for Filing a Claim

Name and Address:

## Claims against the Utah Transit Authority must include the following:

→ ←

1. The completed **NOTICE OF CLAIM FORM** (attached). The completed form must be the original document with the original signature – copies or facsimiles are not acceptable.

2. Relevant documentation, including but not limited to police report(s), witness information and/or statement(s), photograph(s), and/or property damage repair/replacement estimates (at least two). Please note that these items are not required to file a claim, but before payment of a claim will be considered, evidence of liability and damages will need to be provided. For bus passenger injury claims covered under Personal Injury Protection (PIP) additional documentation and forms will be required.

**Your claim must be addressed as follows:**

## Utah Transit Authority

Claims Unit
669 West 200 South
Salt Lake City, UT 84101

**If indicated with an 'X', please return each of the following with the Notice of Claim Form:**

| | |
|---|---|
| **At least two (2) damage estimates** | **-** |
| **Personal Injury Protection Application** | **-** |
| **Medical Authorization Form** | **-** |
| **Medicare Beneficiary Form** | **-** |
| **Medicare Consent to Release Form** | **-** |

This procedure for filing a claim is not to be construed as a waiver or estoppel of any provision of the Utah Governmental Immunity Act.

Utah Transit Authority
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Utah Transit Authority
Claims Unit
669 West 200 South
Salt Lake City, UT 84101

# Notice of Claim Form

**See Utah Code Annotated § 63-30d-401**

## Personal Information

| | | | |
|---|---|---|---|
| Last Name: | First Name: | | |
| Address: | City: | State and Zip Code: | |
| Work Phone: | Home Phone: | Cell Phone: | Email: |
| Social Security Number: | Date of Birth: | Employer: | |

## Accident Information

| | | | |
|---|---|---|---|
| Date of Loss: | Time of Loss: | Location of Loss: | |
| Police Department (if applicable): | | Police Case Number: | |

## UTA Vehicle Information (if applicable)

| | | | |
|---|---|---|---|
| UTA Vehicle Number: | Route Number: | Plate Number: | Direction of Travel: |
| UTA Employee's Name: | UTA Employee's Badge Number: | Vehicle was (circle one): Bus Train Staff Other | |

## Your Vehicle Information (if applicable)

| | | | |
|---|---|---|---|
| Year: | Make: | Model: | Plate Number: |
| Owner's Name (if different than above): | | Owner's Phone: | |
| Owner's Address: | City: | State and Zip Code: | |
| Insurance Company: | Policy Number: | Policy Expiration Date: | |
| Insurance Company Address: | Agent's Name: | Agent's Phone: | |

**(i) A brief statement of facts** (please be as detailed as possible; use additional sheets if needed)

***This information is not to be construed as a waiver of any provision of the Governmental Immunity Act of Utah §63-30D-401. This information is provided to you as a service by the Utah Transit Authority and is not intended as a substitute for legal advice. Utah Transit Authority makes no warranty as to the accuracy or completeness of this information.***

**(ii) The nature of the claim asserted:** (please be as detailed as possible; use additional sheets if needed)

**(iii) The damages incurred by the claimant so far as they are known:** (please be as detailed as possible)

**Injuries Incurred:** (please be as detailed as possible; use additional sheets if needed)

x

Claimant's Signature Date Signed

This form must be signed by the person making the claim or that person's agent, attorney, parent, or legal guardian.
**IMPORTANT!!!** Unsigned Notice of Claim Forms will be returned unprocessed.

***This information is not to be construed as a waiver of any provision of the Governmental Immunity Act of Utah §63-30D-401. This information is provided to you as a service by the Utah Transit Authority and is not intended as a substitute for legal advice. Utah Transit Authority makes no warranty as to the accuracy or completeness of this information.***

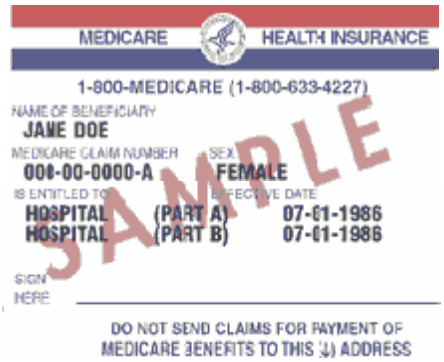
Revised 7/12/13

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 the 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? | □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 Claim Number:** | **Date of Birth (Mo/Day/Year)** | - - |
| **Social Security Number:** *(If Medicare Claim Number is Unavailable)* - - | **Sex** | □Female □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**

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Learn about your letter at *www.msprc.info*

CONSENT TO RELEASE

I hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information related to the injury/illness and/or settlement for the specified date of injury to the individual(s) and/or firm(s) listed below:

CHECK ONE OR MORE OF THE FOLLOWING:

☐ Claimant's attorney _____
(Name and/or firm)

☐ Insurance carrier _____
(Name and/or company)

☐ Other _____ _____
(Explain) (Name and/or firm)

How long can we give out the information? **(Check one Block)**

☐ Ongoing, beginning _____
Month/Day/Year

☐ Limited time _____ through _____
Month/Day/Year Month/Day/Year

☐ One time only