Claim for Damages

Dear Claimant,

To file a Claim for Damages you must fill out the form below as completely as possible. Be sure to include your current address, telephone number and signature in the spaces provided.

In case of vehicle damage, only the registered owner may present a claim for damages and must sign the form.

Mail your signed completed form(s) and any supporting documents to:

OCTA – Risk Management
P.O. Box 14184
Orange, CA 92863-9831
833-711-7475

Claims arising after January 1, 1988 must be filed within 6 months from the date of accident.

If submitting a bodily injury claim, please review and complete the Medicare Reporting Form. Please mail in the completed Medicare Reporting form along with your Claim for Damage.

Claim for Damages

*Please complete all mandatory information

CLAIMANT INFORMATION

Last Name * | First Name * | Middle Name / Initial

Social Security # | California DL # | Birth Date

Street Address *

City | State | Zip * | Telephone Number | Email Address

IF CLAIMANT IS A MINOR PROVIDE PARENT OR GUARDIAN INFORMATION

Last Name * | First Name * | Middle Name / Initial

Street Address *

City | State | Zip * | Telephone Number | Email Address

IF REPRESENTED BY AN ATTORNEY COMPLETE THIS SECTION

Last Name | First Name | Law Firm Name *

Street Address *

City | State | Zip * | Telephone Number | Email Address

INCIDENT INFORMATION

Date of Loss * | Time * | Location & City *

Your Vehicle Direction | On Which Street * | Cross-Street *

Bus # * | Route #

OCTA Vehicle Direction | On Which Street | Operator Name or Badge # *

Claim for Damages

Describe what occurred (if necessary, you may add another page) *

What particular act or omission do you claim caused the injury or damage? *

What property damage or bodily injury do you claim? Give full extent of damage or injury claimed *

The Amount claimed *

Name(s) and address(es) of witness(es)

Name(s) and address(es) of doctor(s)

VEHICLE OWNER COMPLETE THIS SECTION

Name | Driver License #

Address

Telephone | Vehicle Year | Make | Model

Insured? | Vehicle Lic. # | Insurance Tel. #

Carrier | Policy #

Signature of Claimant **Date**

Claims arising after January 1, 1988 must be filed within 6 months from the date of accident. For Law governing filing of claim and statute of limitations as to filing action see Chapter 201 Statuses 1987 (Sec 900 ET SEQ Government Code). For your protection California Law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in State Prison.
Added by Stats. 1989, c. 1119, S 3.

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**