# *VEHICLE COLLISION FORM*

PLEASE TYPE OR PRINT IN INK

Please attach this form to your standard tort claim form, if the claim involves a vehicle collision.

## CLAIMANT AND INCIDENT INFORMATION

CLAIMANT'S NAME (A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT) | DATE OF ACCIDENT(mm/dd/yyyy) | TIME AM ☐ PM ☐

CURRENT STREET (RESIDENCE) ADDRESS | CITY | STATE | ZIP | PHONE HOME WORK

(RESIDENCE) STREET ADDRESS FOR SIX MONTHS PRIOR TO THE ACCIDENT | CITY | STATE | ZIP | EMAIL

State/County/City (if applicable) where occurred | STREET OR HWY | MILEPOST NO. | INTERSECTION OR NEAREST STREET/ROAD

## YOUR VEHICLE INFORMATION (VEHICLE #1)

YEAR | MAKE | MODEL | LICENSE PLATE NO. | WHERE CAN CAR BE SEEN? | WHEN?

NAME OF VEHICLE OWNER | ADDRESS | CITY | HOME AND WORK PHONE

NAME OF DRIVER | ADDRESS | CITY | HOME AND WORK PHONE

DRIVER'S LICENSE NUMBER | STATE OF ISSUANCE | DATE OF EXPIRATION

DESCRIBE DAMAGE | ESTIMATE $ | YOUR INSURANCE COMPANY AND POLICY NO.

## OTHER VEHICLE INFORMATION (VEHICLE #2)

YEAR | MAKE | MODEL | LICENSE PLATE NO. | STATE AGENCY, IF KNOWN

NAME OF OWNER | ADDRESS | CITY | PHONE

NAME OF DRIVER | ADDRESS | CITY | PHONE

DESCRIBE DAMAGE | ESTIMATE $

## OTHER NON-VEHICLE DAMAGE

WAS OTHER (NON-VEHICLE) PROPERTY DAMAGED? IF SO, DESCRIBE WHAT TYPE OF PROPERTY WAS DAMAGED.

NAME OF OWNER | ADDRESS | CITY | PHONE

DESCRIBE DAMAGE | ESTIMATE $

## INJURED PARTIES

| NAME | ADDRESS | PHONE | INJURY | AGE | VEH 1 | VEH 2 | VEH 3 | PED | OTH |
|---|---|---|---|---|---|---|---|---|---|
| | | HOME WORK | | | | | | | |
| | | HOME WORK | | | | | | | |
| | | HOME WORK | | | | | | | |
| | | HOME WORK | | | | | | | |
| | | HOME WORK | | | | | | | |

## WITNESSES

NAME (ATTACH ADDITIONAL SHEETS IF NECESSARY) | ADDRESS | CITY | PHONE

HOME WORK

HOME WORK

HOME WORK

## COMPLETE ALL DETAILS

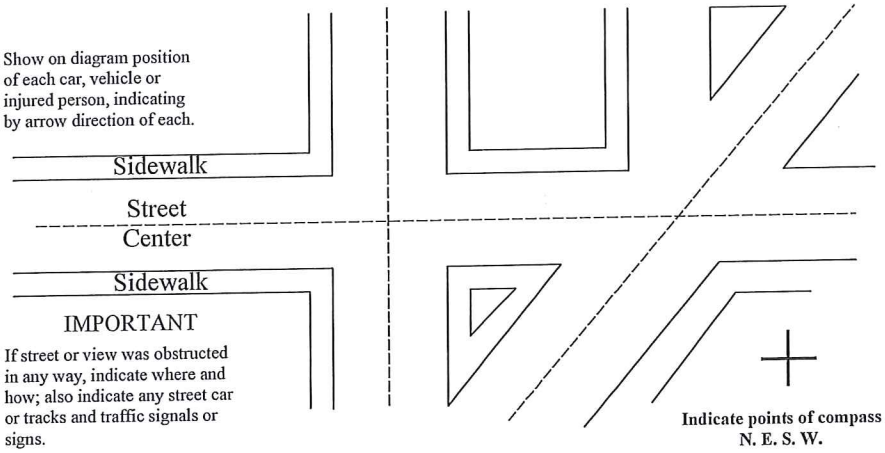
Describe conduct and circumstances causing injury or damages and explain the extent of medical, physical or mental injuries. Please identify name, address, and telephone number of treating physicians and other medical providers. Please attach property damage estimates and/or all medical bills in support of your claim. If necessary, attach additional pages containing information in this format.

☐ Straight Road
☐ Curve – R or L
☐ Level

☐ Hillcrest
☐ Uphill
☐ Downhill

☐ One Lane
☐ One and One-Half Lane
☐ Two Lane or Four Lane

Show on diagram position of each car, vehicle or injured person, indicating by arrow direction of each.

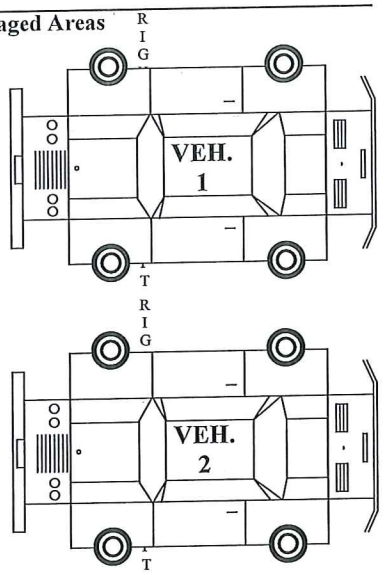



IMPORTANT

If street or view was obstructed in any way, indicate where and how; also indicate any street car or tracks and traffic signals or signs.

Indicate points of compass
N. E. S. W.

**Mark Damaged Areas**




| LIGHT CONDITIONS (CHECK ONE) | TRAFFIC CONTROL | TYPE OF ROAD (CHECK ONE OR MORE) | VEHICLE CONDITION (CHECK ONE OR MORE) | ROAD SURFACE (CHECK ONE) | WEATHER (CHECK ONE) |
|---|---|---|---|---|---|
| 1 ☐ DAYLIGHT | VEHICLE NO. 1 NO. 2 | VEHICLE NO. 1 NO. 2 | VEHICLE NO. 1 NO. 2 | VEHICLE NO. 1 NO. 2 | 1 ☐ CLEAR, CLOUDY & OVERCAST |
| 2 ☐ DAWN | ☐ 1 ☐ SIGNALS | ☐ 1 ☐ ONE WAY | ☐ 1 ☐ DEFECTIVE BRAKES | ☐ 1 ☐ DRY | 2 ☐ RAINING |
| 3 ☐ DUSK | ☐ 2 ☐ STOP SIGN | ☐ 2 ☐ TWO WAY | ☐ 2 ☐ DEFECTIVE HEADLIGHTS | ☐ 2 ☐ WET | 3 ☐ SNOWING |
| 4 ☐ DARK STREET LIGHTS ON | ☐ 3 ☐ FLASHING RED | ☐ 3 ☐ REVERSIBLE ROAD | ☐ 3 ☐ DEFECTIVE REAR LIGHTS | ☐ 3 ☐ SNOW | 4 ☐ FOG |
| 5 ☐ DARK STREET LIGHTS OFF | ☐ 4 ☐ FLASHING AMBER | ☐ 4 ☐ INTER-CHANGE LOOP RAMP | ☐ 4 ☐ TIRES WORN | ☐ 4 ☐ ICE | 5 ☐ OTHER (SPECIFY) |
| 6 ☐ DARK NO STREET LIGHT | ☐ 5 ☐ RR SIGNAL | ☐ 5 ☐ ALLEY | ☐ 5 ☐ PUNCTURED OR BLOWN TIRES | ☐ 5 ☐ OTHER (SPECIFY) | |
| 7 ☐ OTHER (SPECIFY) | ☐ 6 ☐ OFFICER/ FLAGMAN | ☐ 6 ☐ TWO WAY-LEFT TURN LANES | ☐ 6 ☐ OTHER (SPECIFY) | | |
| | ☐ 7 ☐ YIELD SIGN | ☐ 1 ☐ SEPARATED | | | |
| | ☐ 8 ☐ NO TRAFFIC CONTROL | ☐ 2 ☐ DIVIDED | | | |
| | ☐ 9 ☐ OTHER | ☐ 3 ☐ UNDIVIDED | | | |

NAME OF INVESTIGATING POLICE AGENCY:

INVESTIGATING AGENCY REPORT NO.

**A separate claim form should be submitted for each claimant.**

This information is being provided to aid in resolving the claim.

***I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.***

*Signature of Claimant*

*Date and Place (residential address, city and county)*

# MMSEA REPORTING COMPLIANCE DECLARATION

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 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 like the state of Washington), 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. Please 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 the 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**