Property, Personal Injury and/or Auto Damage Claim Packet

Attached please find the one (1) page Claim Form and the two (2) page Medicare & Medicaid Services (CMS) Form that must be completed in full to avoid any delays in the claims review process.

Please return the completed packet to Attn: Trish Smith, First Floor City Hall, City of Joplin, 602 S. Main, Joplin MO 64801 or fax to 417-625-4712 or e-mail PSmith@joplinmo.org.

The City of Joplin **requires two (2) itemized estimates of damages or itemized receipt** showing final payment to be turned in with the attached claim form packet. If you would like to submit photographs of damages or would like to make arrangements to have photographs taken of the claimed damages, through our office, please contact our office, at 417-624-0820 ext. 212. Please reference any police report number you have been given on the attached claim form to include in our review.

Once the attached Claim Form Packet (all three pages) and all itemized estimates/ bills have been submitted back to our office, your claim will be investigated with the relevant department before it is processed. Our claims office will contact you for further information if additional information is required. This process could take up to two (2) weeks minimum, however some claim investigations may take additional time, depending on the claim details and if they need to be reviewed by Council.

If you have any questions or concerns regarding your claim or the claim process, please feel free to call our claim office at 417-624-0820, ext. 212, during regular business office hours of 8:00a.m. to 5:00p.m. (Monday- Friday) We are here to assist you with any questions you may have during this process, if you call and we are on another line or assisting another caller, please leave a detailed message (include First and Last name on the claim, Date of the Claim and Location of the incident) with your specific question. Our office will return your call as soon as possible within a 48-hour time frame.

Thank you

CLAIM FORM

Claimant's Name: (must match Social Security Card)	Home Address:

City:	State:	Zip Code:

Home Phone:	Work Phone:	Cell Phone:

Address: (if different than home)	Date of Birth:	Social Security Number: (if Medicare claim number is unavailable)

Description of what occurred:

_____

_____

Please list injuries, damage or loss incurred (Please provide **2 estimates** of damage or final payment)

A Claim Form submitted without estimates will be on hold until estimates are received.

- ☐ If property damage and you're a renter, please provide landlord contact information
- ☐ If auto damage and you're not the owner, please provide contact information

_____

Date of Incident:		Time of Incident:	

(Without a date, time or location – claim processing will take longer for further research)

Address of Incident:	

Witnesses: (Please provide name and phone number, if available)

Name: _____ Number: _____

Name: _____ Number: _____

Was an emergency response (e.g. police, fire, ambulance) required?	☐ Yes ☐ No

If so, please list responding agency and individual name:

Agency: _____ Police Report #: _____

Name:

I certify that the above information is true. I authorize City Representatives to contact individuals named here to verify this claim.

Signature: Date:

Return completed form to:	Risk Management First Floor City Hall City of Joplin, MO 64801

This Liability Claim Form needs to be returned with the Medicare & Medicaid Services Form

(continued on next page)

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**