Utah Transit Authority-Claims Unit
Email: claims@rideuta.com
Mailing address: 669 West 200 South
Salt Lake City, UT 84101

Notice of Claim Form

See Utah Code Annotated § 63G-7-401

Personal Information

Last Name:	First Name:		
Address:	City:	State and Zip Code:	
Work Phone:	Home Phone:	Cell Phone:	Fax:
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 the 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 §63G-7-401. 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 §63G-7-401. 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.

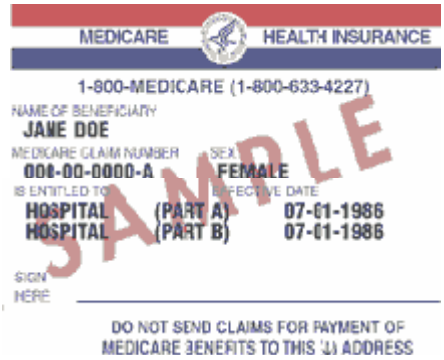
Revised 10/23/2023

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

_____ _____
Beneficiary's Name (please print) Medicare Number

_____ _____ _____
Beneficiary's / Claimant's Signature Date Signed Date of Injury

If your Power of Attorney (POA) or legal representative signs this form for you, a copy of their POA or representation papers must be sent to us with this form.

Completion and signing of this consent form:

- Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
- Allows release of Medicare claims and other information related to your injury/illness.
- Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare Program.

You have the right to revoke your authorization at any time in writing, except to the extent that CMS has already acted based on your permission. To revoke, send a written request to the address listed below.

Medicare Secondary Payer Contractor
Post Office Box 33828, Detroit, MI 48232-5828 Fax: (734) 957-0998