NOTICE OF TORT CLAIM

CLAIMANT REPORT TO: Pittsburg County, Oklahoma

(Name of county you are filing claim against.)

IMPORTANT NOTICE: The filing of this notice in the County Clerk's Office is only the initial step in the claim process and does not indicate in any manner the acceptance of responsibility by the County and or its related entities. Written notice is required by law and shall be filed with the County Clerk within one (1) year from the date of occurrence. It will then be sent to the County Claims of Oklahoma Claims Department located at 429 N.E. 50th Street in Oklahoma City, Oklahoma (Ph# 800-982-6212) for further investigation. Failure to file your claim within such time frame may result in the claim being barred in its entirety. Other limitations to your claim may also apply (See Oklahoma Statutes, Title #51, Sections 151-172).

CLAIMANT(S) INFORMATION: (Each person making a claim must file a separate notice of tort claim)

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Date/Time of Accident: _____ at _____ ☐AM ☐PM

Location of Accident: _____

Description of Accident:

_____

_____

_____

_____

_____

_____

Please identify any witnesses to the accident along with their respective addresses and or phone numbers is available.

1. _____

2. _____

3. _____

INSURANCE INFORMATION:

1. Have you filed a claim with your insurance company for these damages? ☐ Yes ☐ No
2. Do you expect to be compensated for your damages from your insurance company? ☐ Yes ☐ No
3. If you have received payment from your insurance company what was the amount received $_____
4. What is your deductible? $_____

MEDICARE/MEDICAID INFORMATION:

1. Are you currently receiving Medicare? ☐ Yes ☐ No
2. Has any medical bill incurred as a result of this accident been paid by Medicare/Medicaid? ☐ Yes ☐ No
3. If so, please list your Medicare/Medicaid file number: _____

I understand that the Medicare/Medicaid information requested is to accurately coordinate benefits with Medicare/Medicaid and to meet its mandatory reporting obligations under the Medicare Secondary Payer Act 42 U.S., C, Section #1395Y.

_____ _____

Medicare/Medicaid Beneficiary Name (Please print) Medicare/Medicaid Beneficiary Name (Signature)

BODILY INJURY:

List all injuries that you incurred as a result of the above-described accident along with the total cost of medical expenses you have incurred to date along with any anticipated future medical expenses and or lost wages you may incur:

_____

_____

_____

Were you on the job at the time of the accident/injury: ☐ Yes ☐ No

If you were on the job please list the name/address of your employer: _____

_____

PROPERTY DAMAGE:

Please outline all property related damages that you incurred as a result of this accident along with attaching copies of any paid repair bills and estimates for the cost of all repairs:

_____

_____

_____

PERSONAL PROPERTY DAMAGE:

List all personal items that were damaged in the above-described accident along with the age of the item along with the original cost. Also, include the costs to repair and or replace the items you have listed. Attach all receipts and or estimates to verify the amounts claimed along with any photograph's you may have of the damaged personal property.

		Amount Claimed
1.	_____	$_____
2.	_____	$_____
3.	_____	$_____
4.	_____	$_____
	TOTAL AMOUNT CLAIMED	$_____

_____ _____

Signature of Claimant Date