CARMICHAEL WATER DISTRICT
7837 Fair Oaks Blvd
Carmichael, CA 95608
916-483-2452
mail@carmichaelwd.org

CLAIM FORM

(A claim shall be presented by the claimant or by a person acting on his behalf)

1	***Effective January 1, 2010 the Medicare Secondary Payer Act (Federal Law) requires the District/Agency to report all claims involving payments for bodily injury and/or medical treatments to Medicare. As such, if you are seeking medical damages we must have both your Social Security Number and your date of birth.***
	CLAIMANT INFORMATION
	NAME:
	ADDRESS:
	PHONE #: EMAIL:
	FOR MEDICAL CLAIMS ONLY INCLUDE SOCIAL SECURITY AND DATE OF BIRTH BELOW:
	SOCIAL SECURITY #: DATE OF BIRTH:
2	**WITNESS INFORMATION**
	NAME: PHONE #:
	ADDRESS:
3	**INCIDENT DETAILS (description of occurrence, use back of form if necessary)**
	DATE: TIME: PLACE:
	TELL WHAT HAPPENED: (give complete information)
	NOTE: Attach any photographs you may have regarding this claim.
4	**CLAIM DETAILS** *(description of the indebtedness, obligation, injury, damage, or loss incurred so far as know at this time)*
	NOTE: Attach receipts.
5	**EMPLOYEE(S) NAMES** *(list the public employees causing the injury, damage, or loss, if known).*
6	The amount claimed if it totals less than ten thousand dollars ($10,000) as of the date of presentation of the claim, including the estimated amount of any prospective injury, damage or loss, insofar as it may be known at the time of the presentation of the claim, together with the basis of computation of the amount claimed. If the amount claimed exceeds ten thousand ($10,000), no dollar amount shall be included in the claim. However, it shall indicate whether the claim would be a limited civil case.
Date:	Time: Signature:
	ANSWER ALL QUESTIONS. OMITTING INFORMATION COULD MAKE YOUR CLAIM LEGALLY INSUFFICIENT!

FOR OFFICE USE ONLY:	Release Form Sent:
Approved By:	Check Request Sent:
Denied By:	Check Mailed Date:
Date:	Claim to JPIA Date:
Claim Check from JPIA date:	Adm check from JPIA date: