Accident Claim Worksheet

What Happened

Date of accident: _____

Description of accident: _____

Names of parties involved: _____

Names of witnesses: _____

Location of accident: _____

Time of accident: _____

Weather condition (if outside): _____

People Responsible for the Accident

Name: _____

Address:_____

_____

Telephone (work): _____ (home): _____

Insurance company: _____Policy number: _____

Auto license: _____

What person did: _____

Name: _____

Address:_____

_____

Telephone (work): _____ (home): _____

Insurance company: _____ Policy number: _____

Auto license: _____

What person did: _____

Name: _____

Address:_____

_____

Telephone (work): _____ (home): _____

Insurance company: _____ Policy number: _____

Auto license: _____

What person did: _____

Witnesses

Name: _____

Address:_____

_____

Telephone (work): _____ (home): _____

Date of first contact: _____

Written statement: [ ] yes [ ] no

What person saw: _____

.....

Name: _____

Address:_____

_____

Telephone (work): _____ (home): _____

Date of first contact: _____

Written statement: [ ] yes [ ] no

What person saw: _____

.....

Name: _____

Address:_____

_____

Telephone (work): _____ (home): _____

Date of first contact: _____

Written statement: [ ] yes [ ] no

What person saw: _____

Medical Treatment Providers

Name: _____

Address:_____

_____

Telephone: _____

Date of first visit: _____

Date of most recent or last visit: _____

Person to be contacted for medical records: _____

Date requested: _____ Date received: _____

Person to be contacted for medical billing: _____

Date requested: _____ Date received: _____

Reason for treatment and prognosis: _____

.....

Name: _____

Address:_____

_____

Telephone: _____

Date of first visit: _____

Date of most recent or last visit: _____

Person to be contacted for medical records: _____

Date requested: _____ Date received: _____

Person to be contacted for medical billing: _____

Date requested: _____ Date received: _____

Reason for treatment and prognosis: _____

Name: _____

Address:_____

_____

Telephone: _____

Date of first visit: _____

Date of most recent or last visit: _____

Person to be contacted for medical records: _____

Date requested: _____ Date received: _____

Person to be contacted for medical billing: _____

Date requested: _____ Date received: _____

Reason for treatment and prognosis: _____

Other Party's Insurance Company (First Party)

Company name: _____

Address:_____

_____

Telephone: _____

Insured: _____ Claim number: _____

Adjuster: _____

Date demand letter was sent: _____

Settlement amount: _____ Date accepted: _____

Other Party's Insurance Company (Second Party)

Company name: _____

Address:_____

_____

Telephone: _____

Insured: _____ Claim number: _____

Adjuster: _____

Date demand letter was sent: _____

Settlement amount: _____ Date accepted: _____

Communications With Insurer

Date: _____

If oral, what was said: _____

Communications With Insurer

Date: _____

If oral, what was said: _____

Communications With Insurer

Date: _____

If oral, what was said: _____

Communications With Insurer

Date: _____

If oral, what was said: _____

Communications With Insurer

Date: _____

If oral, what was said: _____

Losses

Describe damage to your property: _____

Do you have photos showing damage [ ] yes [ ] no

If Repairable

Estimates for repairs (name of repair shop and amounts of estimates):

_____

Actual

Repair bills (name of repair shop and amounts of bills): _____

If totaled:

Value at the time destroyed: _____

Documentation of value: _____