INITIAL NOTICE OF CLAIM FOR DAMAGES AGAINST:

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Return form to: Qual-Lynx
100 Decadon Drive, Egg Harbor Township NJ 08234

This Form MUST be filled out within 90 days of the accident or you may forfeit your rights.

1. Claimant:

Last Name, First, Middle	Date of Birth
Street Address	Daytime Phone Number
City State Zip Code	Social Security Number

2. If notices and correspondence in connection with this claim are to be sent to a person other than the claimant, complete Item #2:

Name of Person	Mailing Address
Telephone Number	City State Zip Code

Relationship to Claimant: Attorney at law( ) or ____________________
Explain relationship

The occurrence or accident which gave rise to this claim:

3a. ____________________ ____________________
Date Time

b. Describe the location or place of the accident or occurrence.

Municipality	Exact location of the occurrence

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c. Describe how the accident or occurrence happened. If a diagram will assist your explanation, please use the reverse side of this form.

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d. State the name and address of the Public Entity, or entities, that you claim caused your damage.

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State the name of the employees whom you claim were at fault, including any information that will assist in identifying and locating them.

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e. State, in detail, the negligence or wrongful acts of the Public Entity and public employees which caused your damages.

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f. State the name and address of all witnesses to the accident or occurrence.

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g. State the names of all police officers and police departments who investigated the accident.

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4a. Claim for Damages (Check appropriate block.)

( ) Personal Injury ( ) Property Damage

( ) Other – Explain in detail ______________________________________

b. If you claim personal injury:

(1) Describe your injuries resulting from this accident or occurrence.

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(2) Do you claim permanent disability resulting from this injury?

( ) Yes ( ) No

If yes, describe the injuries believed to be permanent.

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(3) For each hospital, doctor, or other practitioner rendering treatment, examination or diagnostic services, state:

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(4) If you claim loss of wages or income as a result of the injury, state:

Name of Employer	Address of Employer
Your Occupation	Date You Became Employed
Rate of Pay	Date of Absence From Work
Total Lost Wages to Date	If Still Out, Expected Date of Return

Note: If your claimed loss of income arises from self-employment or other than wages, attach a calculation showing the basis of your calculation of lost income.

(5) Set forth any and all other losses or damages claimed by you.

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c. If you claim property damage:

(1) Describe the property damage

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(2) The present location and time when the property may be inspected.

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(3) Date property acquired. ______________________________

(4) Cost of property.$______________________________

(5) Value of property at time of accident. $______________________________

(6) Description of damage. ______________________________

(7) Has the damage been repaired? _______________ If so, by whom, when and cost of repairs. ____

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(8) Attach each estimate of repair costs to this form.

(9) Set forth, in detail, the loss claimed by you for property damage.

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d. Set forth, in detail, all other items of loss or damages claimed by you and the method by which you made the calculation.

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5. The amount of the claim. ____

6. Have you made a claim against anyone else for any of the losses or expenses claimed in this notice? ____

If yes, set forth the name and address of all persons and insurance companies against whom you have made such claims.

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7. Are any of the losses or expenses claimed herein covered by any policy of insurance?

If yes, for each such policy, state the name and address of the insurance company, policy number, and benefits paid or payable.

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8a. If this claim involves an automobile, please state:

(1) The name of the insurance company covering the automobile.

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(2) The name of your local insurance agent. ______________________

(3) Your policy number and dates of coverage (if other than automobile).

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b. (1) State the name of your Homeowners', rental, or property insurance company.

(2) The name of your local insurance agent. ______________________

(3) Your policy number. ______________________________

c. If you have any other form or kind of liability insurance, please state:

(1) The name of the insurance company.

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(2) Type of liability coverage.

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(3) The name of your local insurance agent.

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(4) The policy number or numbers.

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9. Have you received, or agreed to receive, any money from anyone for the damages claimed herein? ______________ If so, set forth the details of such agreement.

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10. The following items must be submitted with this notice:

(1) Copies of itemized bills for each medical expense and other losses and expenses claimed.

(2) Full copies of all appraisals and estimates of property damage claimed by you.

(3) Copies of all written reports of all expert witnesses and treating physicians.

(4) A letter from your employer verifying your lost wages. If self-employed, a statement showing the calculation of your claimed lost income.

11. Please specify, if known, whether the claim arises out of any of the following activities of:

(1) Any construction project. ______________________________

(2) Any demolition project. ______________________________

(3) Any road or bridge project. ______________________________

(4) Other. ______________________________

12. State whether the incident has occurred on any sidewalk, street or bridge located in

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13. If yes, please give exact location.

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I hereby certify that the foregoing statements made by me are true, that the attached statements, bills, reports, and documents are the only ones known to me to be in existence at this time. I am aware that if any statement made herein is willfully false or fraudulent, I am subject to punishment as provided by law.

______________________	______________________
Date	Signature of claimant or person filing claim on behalf of claimant

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AUTHORIZATION FOR HEALTH INFORMATION DISCLOSURE

PATIENT INFORMATION

(please print)

Patient Name:______________________________ DOB:__________

Patient Address:______________________________

City:______________________________ State:______ Zip:__________

I hereby authorize______________________________

(Name of physician's office/medical practice disclosing information)

REQUESTOR/RECIPIENT INFORMATION

Please disclose the following protected health information to:

Qual-Lynx
100 Decadon Drive
Egg Harbor Township, NJ 08234

Phone: (609)653-8400
Fax (609) 926-9270

Please indicate the information or types of information to be disclosed: any and all medical records in your possession, including but not limited to any and all office notes, medical records, reports, diagnostic studies, hospital records, operative reports, psychiatric and/or psychological records, bills, etc.

Specify dates (or date ranges) if applicable:

This request is for the purpose of investigation.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in two years or on the following date:______________________.

I understand that any disclosure of information may be subject to re-disclosures by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

I understand that my health record may include information pertaining to the treatment of drug and alcohol abuse, mental illness, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), sexually transmitted diseases, tuberculosis or genetics.

IF YOU DO NOT WISH THIS INFORMATION TO BE RELEASED, PLEASE INITIAL: DO NOT RELEASE___

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization.

A copy of this signed form will be provided to the claimant patient.
Photocopies of this Authorization carry the same authority as the original.

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Signature of Patient or Authorized Representative

____
Date

____
Description of Representative's Authority
(witness signature required)

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Signature of Witness

File #__________