

# Motor Vehicle Accident Claim - Personal Injury Protection (PIP)

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Insurance Carrier: \_\_\_\_\_

Claim Number #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Claims Billing Address: \_\_\_\_\_

\_\_\_\_\_  
City State Zip

What happened?: \_\_\_\_\_

Where did it happen?: \_\_\_\_\_

Is an attorney involved? Yes No

*(If so, please list the name and phone number of attorney currently working your case)*

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

What status is your claim?: Closed Open PIP available PIP exhausted  
*(please circle)*