



TORT & CASUALTY CASE INFORMATION

Complete All Applicable Sections

CLIENT INFORMATION:

Client Name: _____ Date of Birth: _____
State ID # or Social Security #: _____ Date of Incident: _____
Type of Incident (i.e. Auto Accident, Product Liability, Malpractice, etc.): _____
Nature of the injuries: _____

ATTORNEY INFORMATION:

Attorney Name: _____ Law Firm Name: _____
Firm mailing Address or Email Address: _____
Telephone #: _____ Fax #: _____
Date Representation Began: _____ Firm File/Case #: _____

CRIMINAL CASE:

Name of defendant(s): _____
Charge(s): _____
City or County Attorney's Office prosecuting case: _____
Court case Number: _____

INSURANCE CARRIER INFORMATION:

Insurance Name: _____ Adjuster Name: _____
Insurance Mailing Address or Email Address: _____
Telephone #: _____ Fax #: _____
Insured Name(s): _____ Claim #: _____

Name of person completing form: _____
Phone Number: _____
Date _____

Mail, Fax, or Email to: Colorado Department of Health Care Policy and Financing
ATTN: Tort & Casualty Unit
1570 Grant Street
Denver, CO 80203
Fax: 303-866-3552
Email: tort.casualty@state.co.us

