Utah Transit Authority
Personal Injury Protection Information

Revised 11/2016

A passenger on a UTA bus or a pedestrian injured by a bus may be entitled to Personal Injury Protection benefits. To claim any of these benefits, an Application for Benefits - Personal Injury Protection and Authorization to Release Medical Records forms must be completed and returned with the information needed to verify your claim for benefits.

Medical Payments Benefits

The reasonable and necessary medical expenses up to $3,000.

To claim Medical Payments benefits, UTA requires:	►Completed APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION
	►Itemized bills from your medical providers along with supporting treatment notes for each date of service.
	►Completed Medicare Eligibility form.
	► The attached Authorization to Release Medical Records must be signed [UTA may require information directly from the provider before paying bills submitted].

Work Loss Benefits

Loss of gross income and earning capacity from inability to work for a maximum of 52 weeks after the loss. This benefit need not be paid for the first three days of disability unless the disability continues for longer than two consecutive weeks after the date of injury. The maximum amount payable is 85 percent of a loss of gross income or earning capacity, not to exceed $250/week.

To claim Wage Loss benefits, UTA requires:	►Written verification from your employer of your wage or salary and the average hours you work per week.
	►Written description from your employer of the physical requirements of your job.
	►Written verification from your employer of the dates you missed work since the accident.
	►A written release from your treating physician, indicating the dates you are disabled from work, and the date you may return to work.
	►A written description from your treating physician of the physical restrictions you have due to your injury.

Special Damages

An allowance for services actually rendered or expenses reasonably incurred for services that, but for the injury, the medically qualified injured person would have performed for his/her household. This benefit need not be paid for the first three days after the date of injury unless the person's inability to perform these services continued for more than two consecutive weeks. This allowance cannot exceed $20/day for a maximum of 365 days.

To claim the Special Damage allowance, UTA requires:	►A written release from your treating physician indicating the dates you will be unable to work, and when you will be expected to return to work.
	►A written description from your treating physician of the physical restrictions you have due to your injury.
	►Affidavits signed by those who performed the services which you were unable to perform due to the restrictions of your activities indicating what services were performed, when they were performed, how often, what they were paid for their services, and that these were not services which they provided prior to the date of loss.

Other Benefits

Funeral Expenses not to exceed $1,500, and $3,000 for surviving heirs.

To claim these other benefits, UTA requires:	►An itemized invoice of the funeral expenses.
	►A certified copy of the death certificate.
	►Spouse's marriage license and/or children's birth certificate or adoption papers.

Please note: the above requirement lists are intended to assist you in providing appropriate information to present a claim. It is possible that upon review of documents sent to us, UTA will require additional information. You can download forms for your PIP claim from the UTA website, rideuta.com/claims. Please be sure to sign and return the forms as soon as possible.

Please retain this letter for future reference and call the UTA Office of General Counsel – Claims Unit (801) 287-4616, if you have any questions.

APPLICATION FOR BENEFITS - PERSONAL INJURY PROTECTION

Utah Transit Authority
669 West 200 South
Salt Lake City, UT 84101

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE UTAH PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. PAYMENT OF BENEFITS IS NOT AN ADMISSION OF LIABILITY FOR YOUR INJURIES.

IMPORTANT:

1. To be eligible for benefits you must complete and sign this application.
2. You must also sign the applicable forms/authorizations below.

Your name:	Phone: home - work -	
Your address:	Date of Birth: / /	Social Security No.

Date and Time of Accident / / | am or pm	Place of Accident:

Brief Description of Accident (attach a separate sheet of paper if needed):

Describe Your Injury (attach a separate sheet of paper if needed):

Were you treated by a doctor? Yes □ No □	Doctor's Name and Address:
If treated in a Hospital were you: Inpatient □ Outpatient □	Hospital Name and Address:

Did you lose wages or salary as a result of your injury? Yes □ No □	If yes, amount lost to date: $	What is your average Weekly Wage or Salary? $	Are you eligible for Workers Compensation Benefits or benefits under another statutory plan? Yes □ No □

List the Names and Addresses of your employer and other employers for one year prior to the accident date.

Employer Name and Address:	Occupation:	From:	To:
Employer Name and Address:	Occupation:	From:	To:
Employer Name and Address:	Occupation:	From:	To:

Your Signature: Date:
(Parent or Guardian if a minor)

AUTHORIZATION TO PROVIDE INFORMATION

I authorize any employer, insurer, or other person or entity to whom a signed or photo-copy of this authorization is delivered, to furnish all information, reports, or copies of records (whether generated by you or acquired from others by you) which may be requested by the Utah Transit Authority or its representatives.

I also specifically authorize the Utah Transit Authority to obtain copies of any and all wage, workers compensation, or other documentation from any insurance carrier file, which may be contained therein.

I waive any privilege I may have against the disclosure of these records to the Utah Transit Authority.

PRINTED NAME

_____ _____

SIGNATURE (Parent or Guardian if a minor) SOCIAL SECURITY NO. DATE

PLEASE NOTE: THE MEDICARE ELIGIBILITY AND MEDICAL AUTHORIZATION FORMS (ATTACHED HERETO) MUST BE COMPLETED, SIGNED IN ORDER TO PROCESS A CLAIM.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize and request that you release **all medical films and records, including drug, alcohol, and psychiatric records** in your possession for treatment you have provided me for the past ten (10) years.

I authorize the release of this information to **THE UTAH TRANSIT AUTHORITY** and/or its representative for the purpose of verifying, evaluating, and managing my claim. I understand that, once information is disclosed pursuant to this authorization, it is possible that it will no longer be protected by medical privacy laws and may be subject to re-disclosure as necessary to process or pursue this claim.

I reserve the right to revoke this authorization at any time by sending written notification to the Office of General Counsel at the Utah Transit Authority and to your facility.

I understand that this authorization will expire one year from the date of my signature on this form.

PHOTOCOPIES OF THIS AUTHORIZATION ARE AS VALID AS THE ORIGINAL

_____
Signature of Patient (Parent or Guardian if a minor)

_____
Date Signed

_____
Patient's Name (printed)

_____
Street Address

_____
City/State/Zip

_____ _____
Telephone No. SS#

_____
Date of Birth

****THIS IS NOT A RELEASE OF CLAIM FOR INJURIES****
Failure to release this information may result in a denial in whole or in part of this claim.

Mail Records to: **Office of General Counsel**
Claims Unit
Utah Transit Authority
669 West 200 South
Salt Lake City, UT 84101

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to the answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?	☐Yes	☐No
If yes, please complete the following. If no, proceed to Section II.		
Full Name: *(Please print the name exactly as it appears on your SSN or Medicare card if available.)*		
Medicare Claim Number:	**Date of Birth (Mo/Day/Year)**	- -
Social Security Number: *(If Medicare Claim Number is Unavailable)* - -	**Sex**	☐Female ☐Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print) **Claim Number**

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form **Date**

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.

Section III

_____ _____

Claimant Name (Please Print) **Claim Number**

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

_____
_____
_____
_____

_____ _____

Signature of Person Completing This Form **Date**

MSPRC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Learn about your letter at *www.msprc.info*

CONSENT TO RELEASE

I hereby authorize the Centers for Medicare & Medicaid Services (CMS), its agents and/or contractors to release, upon request, information related to the injury/illness and/or settlement for the specified date of injury to the individual(s) and/or firm(s) listed below:

CHECK ONE OR MORE OF THE FOLLOWING:

☐ Claimant's attorney _____ (Name and/or firm)

☐ Insurance carrier _____ (Name and/or company)

☐ Other _____ (Explain) _____ (Name and/or firm)

How long can we give out the information? **(Check one Block)**

☐ Ongoing, beginning _____ Month/Day/Year

☐ Limited time _____ Month/Day/Year through _____ Month/Day/Year

☐ One time only

_____ Beneficiary's Name (please print)

_____ Medicare Number

_____ Beneficiary's / Claimant's Signature

_____ Date Signed

_____ Date of Injury

If your Power of Attorney (POA) or legal representative signs this form for you, a copy of their POA or representation papers must be sent to us with this form.

Completion and signing of this consent form:

- Authorizes release of information to the person named above upon their request. This means that information disclosed to the above named person may be re-disclosed by them and may no longer be protected by law.
- Allows release of Medicare claims and other information related to your injury/illness.
- Is for release of information purposes only and does not affect benefits you are entitled to under the Medicare Program.

You have the right to revoke your authorization at any time in writing, except to the extent that CMS has already acted based on your permission. To revoke, send a written request to the address listed below.

Medicare Secondary Payer Contractor
Post Office Box 33828, Detroit, MI 48232-5828 Fax: (734) 957-0998

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