STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

Please provide the following information pertaining to the claim for which you are requesting Claims Index information. Return the completed form to:

WV Offices of the Insurance Commissioner
Attn: Claims Services
PO Box 50541
Charleston, WV 25305
Fax: 304-558-8948

Date of Request: _____

Claimant Information:
First Name: _____ Last Name: _____

SSN: _____ Claim Number: _____

Requesting Party:
Carrier FEIN: _____

Carrier Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____

Requesters Name: _____

Requesters Title: _____

Signature: _____

To be completed by Claims Services:
Date Received: _____ Date Approved: _____

Approved By: _____

If you have any questions regarding the completion of this form you may contact

Tonya Montez 304-558-6279 ext. 3132 Tonya.R. Montez@wv.gov