

CLAIM AGAINST THE STATE OF NEVADA

TO: Claims Manager
Office of the Attorney General
DMV Legal/Tort Claims
555 Wright Way
Carson City, NV 89711
(775) 684-1252 or (775) 684-1263

Received By AG's Office: For AG's Office Use Only:

Claim # \_\_\_\_\_ Dir. \_\_\_\_\_
X-Ref \_\_\_\_\_ Emp. \_\_\_\_\_
DOL \_\_\_\_\_ State Veh Lic \_\_\_\_\_
B/A \_\_\_\_\_ \$ \_\_\_\_\_
Agency \_\_\_\_\_ Adj \_\_\_\_\_
\_\_\_\_\_ due \_\_\_\_\_

The following information is necessary to fairly evaluate your claim. Please provide complete information. If you need more space, attach a separate sheet of paper. Additional evidence, such as photographs, police reports, etc., should be attached if available. However, such additional evidence will not be returned. Keep copies for your records. PLEASE PRINT LEGIBLY OR TYPE. You must sign the claim form.

YOU ARE NOT REQUIRED TO MAKE A CLAIM PRIOR TO FILING A LAWSUIT.
THE MAKING OF A CLAIM WILL NOT STOP THE RUNNING OF THE APPLICABLE STATUTE OF LIMITATIONS

- You are the claimant if you are making this claim for yourself.
Your Client is the claimant if you are an attorney making a claim on behalf of a client.
Your Company is the claimant if you are making a claim on behalf of a business.
The Insurance Company is the claimant if you represent an insurance company.

1. CLAIMANT'S NAME \_\_\_\_\_
ADDRESS \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ DAYTIME TELEPHONE NUMBER ( ) \_\_\_\_\_

If you prefer to receive correspondence via EMAIL instead of U.S. Mail, please provide your email address:

2. IF CLAIMANT IS A BUSINESS: Name of Employee involved in incident \_\_\_\_\_
Company Contact Person \_\_\_\_\_ Your Reference \_\_\_\_\_

3. IF CLAIMANT IS AN INSURANCE COMPANY: Name of your "INSURED" \_\_\_\_\_
Claim Representative \_\_\_\_\_ Your Claim No. \_\_\_\_\_

4. IF YOU ARE REPRESENTED BY AN ATTORNEY: We will only communicate with you through your attorney. It is not necessary to retain an attorney to file a claim; however, if you have an attorney for this claim, please provide the following information:
Attorney's Name \_\_\_\_\_
Firm's Name \_\_\_\_\_
Address \_\_\_\_\_

Phone Number: ( ) \_\_\_\_\_ File Reference \_\_\_\_\_

5. DATE AND TIME when the incident occurred: \_\_\_\_\_

6. Exact LOCATION where the incident occurred: \_\_\_\_\_

7. IF THIS IS AN AUTOMOBILE ACCIDENT, please supply the following information:

YOUR VEHICLE

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ License Number \_\_\_\_\_

STATE VEHICLE

Year \_\_\_\_\_ Make \_\_\_\_\_ Model \_\_\_\_\_ License Number \_\_\_\_\_

8. State the full names, addresses and phone numbers of all witnesses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. A CLAIM FOR \$\_\_\_\_\_ is hereby made against the STATE OF NEVADA, based upon the following facts:

10. Describe how damage or injury occurred and what the STATE OF NEVADA or its employees did to cause your damage or injury. Give full details:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

A) State of NV Employee's Name \_\_\_\_\_ B) State of NV Agency \_\_\_\_\_

11. Explain and support the amount of damages you have claimed. Please provide a **MINIMUM OF 2 REPAIR ESTIMATES** for property damage. Also include any rental bills, receipts, medical reports, itemized statements, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. If this claim is for personal injury and/or payment of medical expenses you must answer this question: **Are you covered under any type of Medicare Program. NO YES** if yes: Pursuant to Federal Medicare rules, if liability is accepted by the State of NV, you will be required, at a later date, to provide your Medicare Health Insurance Claim Number (HICN).

I, \_\_\_\_\_, do hereby attest under penalty of perjury that I am the claimant named above, that I have read the foregoing claim and know the contents thereof, that the same is true of my own knowledge, except those matters stated upon information and belief, and as to those matters, I believe them to be true, and that THIS IS MY ENTIRE CLAIM AGAINST THE STATE OF NEVADA.

**IF MY CLAIM IS PAID, I FULLY UNDERSTAND THAT I WILL HAVE TO SIGN A GENERAL RELEASE OF ALL CLAIMS IN THE PRESENCE OF A NOTARY PUBLIC FOR THE EXACT AMOUNT I AM CLAIMING BEFORE ANY PAYMENT WILL BE OFFERED TO ME. THIS RELEASE WILL BECOME EFFECTIVE ONLY UPON ACTUAL PAYMENT OF THE CLAIM BY THE STATE OF NEVADA.**

\_\_\_\_\_  
Signature of Claimant (or Company Representative)

\_\_\_\_\_  
Date

**NOTICE:** 197.160 of Nevada Revised Statutes provides that every person who knowingly presents a false claim is guilty of a gross misdemeanor, and is subject to criminal penalties of imprisonment of up to one year, and a fine of up to \$2,000.

**Incomplete or unsigned claim forms will not be accepted and will be returned.**

**Claims may be submitted as follows:**

**Fax: 775-684-4601 or**

**Mail:  
Claims Manager DMV  
Legal/Tort Claims  
555 Wright Way  
Carson City, NV 89711**