

## **Department of Administrative Services** **Guidance Document**

This guidance document is advisory in nature but is binding on an agency until amended by such agency. A guidance document does not include internal procedural documents that only affect the internal operations of the agency and does not impose additional requirements or penalties on regulated parties or include confidential information or rules and regulations made in accordance with the Administrative Procedure Act. If you believe that this guidance document imposes additional requirements or penalties on regulated parties, you may request a review of the document.

# State of Nebraska Tort & Miscellaneous Claim Form

This form is for Tort (Neb. Rev. Stat. § 81-8,209 - § 81-8,235) and Miscellaneous (Neb. Rev. Stat. § 81-8,294 - § 81-8,301) Claims against the **State of Nebraska**.

Only **COMPLETED** and **SIGNED** Claim Forms will be accepted by the Office of Risk Management.

\* Indicates a **REQUIRED** field. If required fields are not filled out, your Claim will not be processed.

<b>FOR OFFICE USE ONLY</b>
<input type="checkbox"/> TORT <input type="checkbox"/> MISCELLANEOUS
Claim Number:

Claimant's Name*:	Claimant's Phone Number*:	Alternate Phone Number:
Claimant's Mailing Address*:	Claimant's Email Address:	Is Claim Work Related? <input type="checkbox"/> YES <input type="checkbox"/> NO
Is Claimant Medicare Eligible*? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is Claimant a State Employee? <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, What State Agency?
Date of Occurrence*:	Total Amount of Claim*:	Place of Occurrence:
Do you have insurance covering this claim? <input type="checkbox"/> YES <input type="checkbox"/> NO		Insurance Deductible Amount:
Name and Address of Insurance Company & Insurance Policy Number:		

Name, Address, and Phone Number of Attorney, if any:

In the below space, please provide a detailed itemization of all known facts/circumstances/damages leading to your claim. Identify all property, places, and people involved. Include names, addresses, and phone numbers of witnesses, if any. The information provided below, along with the findings of the investigating agency, will form the basis of any decision.\*

Claimant Signature\*:

Date\*:

Under Penalties of law, I declare that I have examined this statement and that it is, to the best of my knowledge and belief, true, complete, and correct, and that I am duly authorized to sign this statement.	
Please include copies of any supporting documents that may be relevant to your claim including, but not limited to, Photos, Invoices, Receipts, Police Reports, Estimates, Medical Bills, Expense Reports, etc.	
<b>Make and keep copies of all documentation submitted as copies will not be provided.</b>	

Claim form and supporting documents can be emailed to: [as.riskmanagement@nebraska.gov](mailto:as.riskmanagement@nebraska.gov)  
 Or mailed to: Office of Risk Management, PO Box 94974, Lincoln, NE 68509-4974  
 Questions? Call the Office of Risk Management at (402) 471-2551

