Claims Processing Form

This form is required when submitting documents for claim processing. PLEASE PRINT CLEARLY AND COMPLETE ALL APPLICABLE SECTIONS

NCN Member/Account Name:_____

Location/Branch (if applicable):_____

Technician:_____

MYNCN Portal Claim ID# NCN-2021_____

NCN Product: ☐ **Invoice** ☐ **Estimate**

Claim Type: ☐ **Residential** ☐ **Commercial**

Loss Type: ☐ **Water** ☐ **Mold** ☐ **Reconstruction**
☐ **Structural Cleaning** ☐ **Content Cleaning**
☐ **Content Pack-Out/Pack-Back**

Property Owner/Insured Information

Owner/Insured Name(s):_____

Property Loss Address:_____ Apt/Suite/Bldg:_____

City:_____ State:_____ ZIP Code:_____

Billing Address (if different):_____ Apt/Suite/Bldg:_____

City:_____ State:_____ ZIP Code:_____

Phone: ☐ Home ☐Work ☐Cell: (_____)_____ Email:_____

Alternate Phone: ☐ Home ☐Work ☐Cell: (_____)_____

Insurance Information

Insurance Company:_____Phone: (_____)_____

Insurance Claim #:_____ Policy#:_____ Effective Date:_____

Field Adjuster:_____ Phone: (_____)_____

Field Adjuster Email: :_____ Alternate Phone: (_____)_____

Claim Examiner/Inside Adjuster:_____ Phone: (_____)_____

Claim Examiner/ Adjuster Email:_____ Alternate Phone: (_____)_____

Equipment Travel, Documentation, Set Up, Monitoring, Take Down

Day of Week	Date	Techs/Hours Ea.	After Hours
		TECHS HRS	☐
		TECHS HRS	☐
		TECHS HRS	☐
		TECHS HRS	☐
		TECHS HRS	☐
		TECHS HRS	☐
		TECHS HRS	☐

Project Management: ☐ **Yes** ☐ **No** **# Hours:**

PPE: ☐ Basic Charge ($65) **OR**

Sets (Suit with N-95 Mask, Gloves) _____ EA X _____DAYS

Respirators: ☐ Full-face ☐ Half-face _____EA X _____DAYS

Respirator Cartridges (PER PAIR): _____

Claim Information

Date Of Loss:

Date Of Service:

Emergency Service Call: ☐ **During Hours** ☐ **After Hrs**

Date of Completion:

Water Category: ☐ 1 ☐ 2 ☐ 3

Water Class: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Number of Levels (Stories) Affected:

Deductible: $ **Deductible Collected: $**

Overhead & Profit: ☐ **Yes** ☐ **Yes (Cumulative)** ☐ **No**

Thermal Imaging: (MUST HAVE IMAGES) **Fee: $:**

Test: ☐ **Air/Mold** ☐ **Lead** ☐ **Asbestos** ☐ **ATP** **Fee: $**

Equipment Fuel: ☐ **Yes** ☐ **No**

Type: **Gallons:** **Fee: $**

Debris: ☐ **Pickup Truck** ☐ **Dump Truck** ☐ **Dumpster**

Quantity:_____ _____ Size:_____

NCN Fee/3rd Party Review: ☐ **Yes** ☐ **No** **Fee: $**

Cause and Origin of Loss:

Claim Comments: (e.g. additional information for Cat 2 or Cat 3 justification; extended drying time information, air scrubber justification, etc.)

Additional Information (e.g adjuster approval details for material tear out, etc.)