



Consumer Services and Market Conduct Branch  
 300 South Spring Street, South Tower  
 Los Angeles, CA 90013  
 (800) 927-HELP  
 (213) 897-8921  
 www.insurance.ca.gov

## AUTO BODY REPAIR SHOP REPORT FORM

Name of Automobile Body Repair Shop:			Business Phone:
Address:		Name of Reporting Person:	
City:	State:	ZIP:	Position:

1. Complete name of insurance company involved:
2. Are you reporting a denial in an insurer's Direct Repair Program?    Yes ___ No ___    If Yes, Skip to Question 8.
3. Type of Insurance:    AUTO
4. Name and Address of the policyholder/claimant/customer:
5. Policy identification number:
6. Claim number:
7. Date loss occurred or began:
8. Name of Adjuster or Insurance Company Representative
9. Have you reported this to any other governmental agency?    Yes ___ No ___ <i>If yes, Please give the</i> <i>Name of the Agency:</i> _____ <i>File number, if known:</i> _____
10. Have you previously written to the California Department of Insurance about this matter? Yes ___ No ___    File number (if available) _____    Date submitted _____

11. Briefly, describe the details of the transaction and provide any documentation to support your allegations. <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
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\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date