STATE OF CALIFORNIA

Ricardo Lara, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
CONSUMER SERVICES AND MARKET CONDUCT BRANCH
300 SOUTH SPRING STREET, SOUTH TOWER
LOS ANGELES, CA 90013
www.insurance.ca.gov
CSD-005
Revised: 12/18/2020

AUTO BODY REPAIR SHOP REPORT FORM

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

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** ☐
If yes, Please give the
Name of the Agency: _____ *File number, if known:* _____

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.

_____ _____
Signature **Date**