Print Form

PUBLIC SPECIAL COMMODITIES DIV, INC CLAIM FORM

Company Name	**Claimant's #**	**Date Prepared**
Address or PO Box	**Carrier Pro #**	**Freight Bill Date**
City, St, Zip	**Claim is for**	**Total Amt of claim**

CLAIM IS FOR THE FOLLOWING DESCRIBED SHIPMENT

Consignee	**Destination**
Shipper	**Origin**
Claim Against/Carrier	**Total weight/Pieces of shipment**

DETAILS OF HOW CLAIM AMOUNT IS DETERMINED

Number of pieces	Description of articles	Amount
	Total	

Comments

DOCUMENTS NEEDED IN SUPPORT OF YOUR CLAIM

☐ Original Bill of Lading

☐ Delivery Receipt

☐ Carriers Inspection

☐ Material & Labor rate per hr

☐ Original Invoice/Cost Invoice

Signature X_____Date_____