



Healthcare Reporting Form

Please attach any pertinent documents or correspondence, including internal incident reports (if applicable).

Please select if applicable: ☐ Precautionary Incident Report ☐ Notice of Intent ☐ Lawsuit ☐ Records Request

INSURED INFORMATION		Policy Number:	
Facility Name:			
Address:		Phone:	
		Fax:	
Policy Holder:			
Address:		Phone:	
		Fax:	
Main Contact:		Main Contact Phone:	
		Main Contact email:	

REPORTER INFORMATION		Relationship to Insured:	☐ Insured ☐ Agent ☐ Claimant ☐ 3 rd Party
Name:			
Company:		Email:	
Address:		Phone:	
		Fax:	
Will you be the Main Contact to the Claim?	☐ Yes ☐ No	Would you be the recipient for customer service surveys?	☐ Yes ☐ No

INCIDENT INFORMATION			
Claimant Name:			
Claimant Address:		Phone:	
		Email:	
Date of Incident:		Date Insured was Notified:	
Brief description of the incident:			
Location of Incident:	(e.g., emergency dept., surgical suite, labor & delivery, your office, patient room, etc.):		
Is the loss location the same as the insured company address? Y/N:		☐ Yes ☐ No	
If Loss Location address is different:			
Attorney Represented:	☐ Yes ☐ No	Fatality: ☐ Yes ☐ No	

Has one of the following been filed:	☐ Lawsuit ☐ Subpoena ☐ Disciplinary Action ☐ Official Report		If a law suit was filed: city, state and zip code where it was filed:		
Claimant Attorney:	Phone:		Claimant Law Firm:	Phone:	
	Fax:			Fax:	
	Email:			Email:	
	Address:			Address:	
Witness to the Event:	Name:				
	Phone:				
	Email:				