Supplement Claim Information Form

(make copies of this page as needed)

1. Name of patient: ____ Age ____ ☐ Male ☐ Female
2. Describe the allegation made by claimant: ____
3. Date claim was made or filed: ____ 4. Date of alleged incident: ____
5. Insurance company: ____
6. What is the present condition of the patient? ____
7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ☐ Yes ☐ No
8. Status of claim (check applicable answer):

☐ Suit threatened, no action taken
☐ Suit filed but dropped by claimant
☐ Summary judgement in your favor
☐ Suit settled out of court
a. Date claim paid: ____
b. Amount paid: ____
c. Did you want to settle this claim? ☐ Yes ☐ No

Court outcome in your favor:
☐ Jury verdict
☐ Directed verdict

Court outcome in favor of plaintiff:
☐ Jury verdict
☐ Directed verdict
Reserve Amount: ____

Unresolved/Open Claim:
☐ Awaiting mediation
☐ Awaiting court action
Reserve Amount: ____

9. Name and address of the attorney assigned to your case: ____
10. To your knowledge, was any settlement paid by anther party involved (i.e., P.A., P.C., partners, employees. etc.) ? ☐ Yes ☐ No
11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim:

If reporting more than one claim, please photocopy this form, and complete a separate form for each. Attache additional sheets if needed for adequate explanation. All questions must be answered or marked Not Applicable (N/A).

Signature ____ Print Name ____ Date ____