FIRST REPORT OF A NEW CLAIM OR INCIDENT

Please check the appropriate box:

☐ Precautionary/Potential
☐ Medical Records Request
☐ Deposition Notice
☐ Board Investigation
☐ Letter of Intent
☐ Pre-Litigation Notice
☐ Lawsuit/Panel
Date Filed: ____
Date Served: ____
☐ Cyber

Insured Information

Group Name: ______________________________

Contact Person: ____________________ Title: ____________________

Phone No.: ____________________ Email: ____________________

Insured Clinician(s): ____________________ Phone: ____________________ Email: ____________________

Insured Clinician(s): ____________________ Phone: ____________________ Email: ____________________

Policy Number: ____________________ Effective Date of Policy: ____________________

Patient Information

Name: ______________________________

Address: ______________________________

City / State / Zip: ______________________________

Date of Birth / Age: ____________________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Incident Information

Date of Incident: ______________

Name of Facility: ______________________________

Address: ______________________________

City / State / Zip: ______________________________

Brief Treatment/Incident Synopsis

Please limit this report to the general synopsis of the insured's treatment of the patient. (If using the online version, the space will grow.)

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Submitted By: ____________________ Date Submitted: ____________________

Phone No: ____________________ Email: ____________________

Submit confidential form and attachments to: claims@medchoicerrg.com