SUPPLEMENTAL CLAIMS INFORMATION

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

1. Patient's name: _____
2. Date reported to insurance company: _____
3. Name of Insurance Company: _____
4. Date of incident and your treatment: _____
5. Allegations: _____

   _____

   _____
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 judgment 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 Amt. of loss payment: _____	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 another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ..... YES ☐ NO ☐

    If "yes", amount was _____
11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: _____

    _____

    _____

    _____

Signature: _____ **Date:** _____

Name (Printed): _____