



# HEALTHCARE PROVIDERS INSURANCE EXCHANGE

## Claim/Suit/Incident Supplement

Name of Applicant \_\_\_\_\_

Claim or Incident No. \_\_\_\_ of \_\_\_\_ Name or initials of patient \_\_\_\_\_  Male  Female

Date of Incident \_\_\_\_\_ Date reported to your insurer \_\_\_\_\_ Has a suit been filed?  Yes  No

Location of Incident  Hospital  Office  Other \_\_\_\_\_ Insurance Company \_\_\_\_\_

Allegations. Provide a narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, etc.). If additional space is required, attach a second sheet of paper.

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Status  Open Reserves \$ \_\_\_\_\_  Residency/Fellowship  
 Closed Closure Date \_\_\_\_\_  Hospital incident report completed  
 Claim dismissed or withdrawn  
 Settlement out of court  Arbitrated  Court trial verdict  
Amount paid on your behalf \$ \_\_\_\_\_  
Amount paid on behalf of all defendants \$ \_\_\_\_\_

Claim or Incident No. \_\_\_\_ of \_\_\_\_ Name or initials of patient \_\_\_\_\_  Male  Female

Date of Incident \_\_\_\_\_ Date reported to your insurer \_\_\_\_\_ Has a suit been filed?  Yes  No

Location of Incident  Hospital  Office  Other \_\_\_\_\_ Insurance Company \_\_\_\_\_

Allegations. Provide a narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, etc.). If additional space is required, attach a second sheet of paper.

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Status  Open Reserves \$ \_\_\_\_\_  Residency/Fellowship  
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 Claim dismissed or withdrawn  
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Amount paid on your behalf \$ \_\_\_\_\_  
Amount paid on behalf of all defendants \$ \_\_\_\_\_

If additional space is required, photocopy this form as needed.

Note: You may be requested to provide additional documentation such as office records, operative reports, discharge summaries, x-rays, etc. No application can be approved without complete and accurate claim information.