



75 Iron Point Circle, Ste. 200 Folsom, CA 95630 (916)850-7300

Please email the completed form along with your file to medmalclaims@prismrisk.gov

MEDICAL MALPRACTICE PROGRAM NOTIFICATION OF CLAIM/INCIDENT FORM

INSTRUCTIONS:

1. Attach a copy of the verified claim and/or a copy of the summons and complaint.
2. Cross reference other previously reported claimants, if any.

ENTITY	Name of Entity		Claim Number	
	Adjuster		Deductible/SIR Level	
	Telephone			
	Defense Attorney		Telephone	

CLAIMANT	Name of Claimant		Age/D.O.B.	
	Occupation		Married/Depend.	
	Claimant's Attorney		Telephone	

DATES	Loss Date		☐ Yes - Litigated	☐ No - Litigated
	Claim Date		Litigate venue	
	Rejection			
	Date Suit Filed		Date Suit Served	

LOSS	Location:	
	Description:	

INJURIES & DAMAGES	Alleged Injuries/Damages:
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EMPLOYEE / CONTRACTOR	Identify relationship to Entity (*provide contract if applicable):
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AMOUNTS (MM1 Only)		Indemnity	Legal	Expense	Adjusting	Total
	Amount Claimed					
	Established Res.					
	Paid to Date					
	Reserve Balance					

EXCESS REPORTING REQUIREMENTS: Immediate reporting is required for all claims that are reasonably likely to jeopardize the retention, including but not limited to the following:

REPORTING REQUIREMENTS

Refer to the Med Mal Claims Guidelines or your MOC for specific reporting requirements.

Reported By: Email: Date: