PRISM

P.O. Box 278, Rancho Cordova, CA 95741 – (916) 859-4800

Please email the completed form along with your file to medmalclaims@georgehills.com

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:

EMPLOYEE / CONTRACTOR	Identify relationship to Entity (*provide contract if applicable):

		Indemnity	Legal	Expense	Adjusting	Total
AMOUNTS (MM1 Only)	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: