231 South Bemiston. Suite 1000
St. Louis, MO 63105
314-721-2366

REPORT OF CLAIM AND POTENTIAL CLAIM (INCIDENT) FORM

Physician Name____________________________________ Policy No.______________________

Office Number____________________________ Cell Number________________________________

Email: ____

Claim or Potential Claim Information

1. Patient/Claimant Name ________________________________ Age_____
   Gender ___ Male ___ Female
2. Date and Place of Alleged Incident or Claim ____
3. Describe in detail below the circumstances of the claim, incident or unexpected result with the dates and length of any treatment or professional health care services you are alleged to have rendered or failed to render, results of treatment, events leading up to a diagnosis and any other facts pertinent to the incident or claim. Use separate sheet(s) of paper as needed and attach to this report.

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4. If patient is deceased, explain the loss or causes of death, if known _________________

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5. Have you received any oral or written communications from an attorney or law firm?
   Check that which applies ___ Yes ___ No
   If yes, describe, if not described above, and please enclose any such written communications with this form.

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6. Has a suit or summons been filed against you? Check that which applies: __ Yes __ No
   If yes, enclose a copy of the complaint or summons and any other pleadings received.

7. When (month and year) was your first notice of this incident or claim? ________________

_____________________________________ ______________________________

Signature of Insured **Date**

State of ____________)
)SS
County of __________)

Subscribed and sworn to before me, a Notary Public. ______________________________
Notary Public

My Commission Expires: Date _________________________