**MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND**

**CLAIM REPORT BY INSURER OR SELF-INSURER**

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| **1a. Insurer or Self-Insurer Name & Address:** | **1b. Claim File #:****Policy #:****Policy Type: CM\_\_\_\_ OC\_\_\_\_ OP\_\_\_\_ PA\_\_\_\_ RE\_\_\_\_ TA\_\_\_\_****Policy Effective Dates:****Primary Policy Limit:** |
| **2a. Health Care Provider Full Name, Employer’s Name & Address:** | **2b. Date of Birth:****PA License #:****Professional School:****Year of Graduation:** |
| **3a. Claimant (Injured Person) Full Name & Address:** | **3b. Date of Birth:****If unknown – age at time of incident:** **Gender: Occupation:** **Social Security #:** |
| **4a. Starting Date of Alleged Malpractice:** **Ending Date of Alleged Malpractice:** **Excess\_\_\_\_ Section 715\_\_\_\_ Drop Down\_\_\_\_** | **4b. Date Claim First Reported to Insured:****Date Claim First Reported to Insurer:****Date of Serious Event Notification to Claimant:****Date Suit Filed/Demand for Damages (whichever is earlier):** |
| **5. Place Alleged Injury Occurred:** |
| **6a. Severity of Injury (use numerical codes in Claim Reporting Guidelines):\_\_\_\_\_\_\_\_\_****6b. ICD 9/10 Codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****6c. Nature of Treatment Giving Rise to Claim including Principal Alleged Injury (attach statement of facts, if desired):** |
| **7. Claimant Present Condition and Prognosis:** |
| **8. Additional Defendants:** | **Additional Defendants’ Insurers (if known):** |
| **9. Plaintiff Attorney (Name, Address & Phone #):** |
| **10. Defense Attorney (Name, Address & Phone #):** |
| **11. Insurer Claim Reserve:** |
| **I attest that I am the authorized representative of the insurer stated in block 1a.** |
| **12.****Preparer Name Preparer Email Address****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Preparer Title Phone Number** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ext. \_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_****Preparer Signature Date** |

**Form C-416 (Revised May 2015)**