PROFESSIONAL LIABILITY INCIDENT REPORT

Medical Professional Liability | Claims, Suits & Incidents

GNP INSURANCE BROKERAGE

If reporting on behalf of multiple insureds, complete a separate form for each insured.

* *Required information*

INSURED / PROVIDER INFORMATION

* INSURED FULL NAME & PROFESSIONAL DESIGNATION

INSURED CORPORATION NAME (IF APPLICABLE)

* INSURED PHONE NUMBER

* INSURED EMAIL

* MAILING ADDRESS (USPS)

POLICYHOLDER NAME

INSURANCE CARRIER

POLICY NUMBER(S)

Is this insured / provider a W-2 employee? ☐ Yes ☐ No ☐ N/A

IF YES, DATE OF HIRE

END DATE

If no, attach a copy of any relevant contract (e.g., independent contractor agreement).

* PREFERRED CONTACT NAME (IF DIFFERENT FROM INSURED)

* CONTACT PHONE

* CONTACT EMAIL

REPORT TYPE

***Select one:**

☐ **Lawsuit / Panel / Pre-Suit** (summons & complaint, panel, pre-suit) DATE SERVED

☐ **Claim** (demand for money or services)

☐ **Notice Only** (unexpected outcome)

☐ **Other** (deposition request, records request, board complaint, etc.)

IF OTHER, PLEASE DESCRIBE

* Was this incident previously reported to any insurance carrier? ☐ Yes ☐ No

IF YES, CARRIER NAME(S)

REPORT DATE

CLAIM NUMBER

PATIENT INFORMATION

* PATIENT NAME

DATE OF BIRTH

SSN (MINIMUM LAST 5 DIGITS)

ADDRESS

PHONE NUMBER

EMAIL

Gender: ☐ Male ☐ Female ☐ Unknown

Medicare Beneficiary: ☐ Yes ☐ No ☐ Unknown

HICN / MBI NUMBER

* IF MINOR PATIENT, GUARDIAN NAME & RELATIONSHIP

INCIDENT INFORMATION

* DATE OF INCIDENT

FIRST DATE OF TREATMENT

LAST DATE OF TREATMENT

* INCIDENT LOCATION INCLUDING PHYSICAL ADDRESS

* BRIEF DESCRIPTION OF INCIDENT, INCLUDING ANY DEADLINES

* WITNESSES TO THE PROFESSIONAL INCIDENT (INCLUDING OTHER TREATING PROVIDERS)

REPORTING INFORMATION

* REPORTER'S NAME

* TITLE OF REPORTER

* DATE FORM COMPLETED

* PHONE NUMBER

* EMAIL

Please attach any summons, complaint, demand letters, contracts, and related communications when submitting this form.

CONFIDENTIAL — DO NOT PLACE IN PATIENT'S MEDICAL RECORD

Prepared in anticipation of litigation