



CLAIMS INFORMATION FORM

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED FOR ADDITIONAL CLAIMS YOU ARE REPORTING TO FPIC.

NOTE: THIS CLAIMS INFORMATION FORM PERTAINS TO LAWSUITS, CLAIMS OR DEMANDS FOR ARBITRATION OR INCIDENTS WHICH COULD LEAD TO CLAIMS. A CLAIMS FORM *MUST* BE COMPLETED FOR EACH LAWSUIT, CLAIM, DEMAND FOR ARBITRATION OR INCIDENT. SUFFICIENT INFORMATION MUST BE PROVIDED TO EVALUATE THE MEDICAL ASPECTS OF THE CASE SPECIFICALLY RELATING TO THE PHYSICIAN'S INVOLVEMENT.

1. PATIENT'S NAME: _____ 2. AGE: _____ 3. SEX (M/F): _____

4. YOUR RELATIONSHIP TO PATIENT (I.E. ATTENDING PHYSICIAN, PRIMARY SURGEON, ASST. SURGEON, ETC):

5. DATE OF INCIDENT: _____ / _____ / _____ 6. LOCATION: _____

7. INSURANCE CARRIER: _____ 8. OTHER DEFENDANTS: _____

9. PRESENT STATUS: OPEN CLOSED _____ / _____ / _____
DATE

INCIDENT ONLY 90-DAY NOTICE SUIT FILED SUIT SERVED ARBITRATION

METHOD OF CLOSING: DISMISSED DEFENSE VERDICT

SETTLED AMOUNT PAID ON YOUR BEHALF: \$ _____ TOTAL SETTLEMENT: \$ _____

JUDGMENT AMOUNT PAID ON YOUR BEHALF: \$ _____ TOTAL SETTLEMENT: \$ _____

THE FOLLOWING QUESTIONS SHOULD BE ANSWERED IN EXPLICIT CLINICAL DETAIL TO ALLOW PROPER EVALUATION BY THE FPIC UNDERWRITING DEPARTMENT. ATTACH ADDITIONAL SHEETS AS REQUIRED.

10. PATIENT'S ALLEGATIONS OR CIRCUMSTANCES BROUGHT TO YOUR ATTENTION: _____

11. CONDITION AND DIAGNOSIS AT TIME OF INCIDENT: _____

12. DATES AND DESCRIPTION OF TREATMENT RENDERED: _____

13. CONDITION OF PATIENT SUBSEQUENT TO TREATMENT (AND DATES OF FOLLOW-UP TREATMENT):

I UNDERSTAND INFORMATION SUBMITTED HEREIN BECOMES PART OF THE FPIC'S NAMED INSURED'S RECORDS.

_____/_____/_____
DATE

PHYSICIAN'S NAME (PLEASE PRINT)

PHYSICIAN'S SIGNATURE