MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND
CLAIM REPORT BY INSURER OR SELF-INSURER

1a. Insurer or Self-Insurer Name & Address:	**1b. Claim File #:** **Policy #:** **Policy Type: CM ____ OC ____ OP ____ PA ____ RE ____ TA ____** **Policy Effective Dates: to** **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.**

_____ **Date**

Preparer Signature