PROASSURANCE
MEDICAL MALPRACTICE INSURANCE

ProAssurance Incident Reporting Form

Please Note: If a report is being made on behalf of multiple insureds, complete and return an additional form for each insured for whom a report is being made.

*Required information to report to ProAssurance

Insured/Provider Information

***Insured Full Name and Professional Designation:** _____

Insured Corporation Name (if applicable): _____

***Insured Phone Number:** _____ ***Insured Email:** _____

***USPS Address:** _____

Policyholder Name: _____ **Policy Number(s):** _____

Is this Insured/Provider a W2 employee?: ☐ Yes ☐ No ☐ N/A **If yes, Date of Hire:** _____ **End Date:** _____

If no, include a copy of any relevant contract (e.g., independent contractors).

***Preferred Contact Name (if different from Insured):** _____

***Contact Phone:** _____ ***Contact Email:** _____

***Report Type**

☐ Lawsuit/Panel/Pre-Suit (service of Summons and Complaint, Panel Proceeding, or 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 ProAssurance or any other insurance carrier? ☐ Yes ☐ No

If yes, list carrier name(s), report date, and claim number:

form continues

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ProAssurance Incident Reporting Form *continued*

Patient Information

***Name:** _____ **DOB:** _____

SSN (minimum last 5 digits): _____ **Address:** _____

Phone: _____ **Email:** _____

Gender: ☐ Male ☐ Female ☐ Unknown **Medicare:** ☐ Yes ☐ No ☐ Unknown

HICN/MBI #: _____

***If minor patient, Guardian Name and 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 (summary):**

***Witnesses to the Professional Incident (including other treating providers):**

***Reporter's Name:** _____ ***Title of Reporter:** _____

***Phone:** _____ ***Email:** _____

***Date Form Completed:** _____

Please submit this completed form, and any additional relevant information including legal documents, contracts, and communications as attachments, to ReportClaim@ProAssurance.com. An autogenerated email will be sent to you confirming the report. Please reply to the autogenerated email with any additional information.

DO NOT PLACE IN PATIENT'S MEDICAL RECORD

(Prepared in anticipation of litigation)