

Physician Incident / Claim Report Form

CONFIDENTIAL: Prepared in anticipation of litigation.

(Completion of this report is not to be construed as an admission of liability, staff error or compromised quality of care.)

**Fax record to Campania Claims Department
at (703) 242-8040**

Insured Physician Name: _____

Name of Practice : _____

Contact: _____ Phone: _____

City: _____ State: _____ Fax: _____

Name of Patient: _____ Age: _____

Status: Patient Visitor

Date Incident/Claim Received: _____

Manner Incident/Claim Received (mail, process server, etc.): _____

If known

Date of Incident: _____

Date of Last Treatment: _____

Brief Description of Incident: _____

Patient Diagnosis: _____

Attach a copy of claim notification, correspondence asserting a claim, legal notice/lawsuit and all such correspondence.

Name of person completing Report (if other than above practice contact): _____

Title: _____ Phone: _____

Date of Completion: _____

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