COVERYS®

MHA INSURANCE COMPANY
MEDICAL PROFESSIONAL LIABILITY
NOTIFICATION OF INCIDENT/CLAIM FORM
p 517.886.8381
f 517.327.4617

Named insured: _____

Additional named insureds: _____

Location of incident: _____

Date received: _____

Reason for notification:
Incident □ Claim □ Medical payments □ NOI □ Summons & complaint □ Prop damage □ 180-day

Date of incident: _____

Patient information

Name: _____ **Date of birth:** _____

Address: _____ **Phone number:** _____

_____ **Gender:** _____

_____ **Marital status:** _____

SSN: _____

Contact person for patient: _____

Occurrence: Brief description of claim to include allegations & time frames (use additional pages if necessary)

_____

_____

_____

Injury: _____

_____

Others involved: (physicians, nurses, etc.):

Name	Relationship	Insurer/limits	Notice received	
_____	_____	_____	Yes___	No___
_____	_____	_____	Yes___	No___
_____	_____	_____	Yes___	No___

Description of last contact with patient or other pertinent information: _____

_____

_____ _____ _____

Signature **Phone number** **Date**

_____

Email address