CLAIMS REPORTING PROCESS

ALL INCIDENTS, CLAIMS AND SUITS ARE TO BE REPORTED TO:

Hospital Claims Mailbox: prihospitalclaims@medmal.com

Claims Telephone: (516) 277-4194

Address: **1800 Northern Boulevard**
Roslyn, New York 11576

Fax: **(516) 684-2359**

Claims/Summonses: Please include a copy of the claim letter or Summons and Complaint along with the attached form "Insured's Report of Incident/Claim/Subpoena/Summons." The attached form should be completed in its entirety.

Incidents: Please include a copy of any incident report, NYPORTS report, patient or attorney request letter for medical records or other relevant correspondence along with the attached form "Insured's Report of Incident/Claim/Subpoena/Summons." The attached form should be completed in its entirety.

Types of incidents to report: anything out of the normal course of treatment for the patient should be reported to PRI. Examples of reportable incidents include but are not limited to; birth injuries/low apgar scores, maternal complications/injuries during childbirth, OR complications, returns to the OR, wrong site, wrong side surgery, medication errors, slips/ falls, IV infiltrates, unexpected deaths, failure to diagnose, incorrectly interpreted x-rays, labs, etc.

Notification to client: You will be notified in writing by the assigned Claims Representative once a file has been established. Copies of patient medical records (do not include radiological films) should be forwarded to the Claims Representative once you have received notice from them.

HEALTHCARE FACILITY

REPORT OF INCIDENT/CLAIM/SUBPOENA/SUMMONS

To: **PRI – Claims Dept**.
Email: **prihospitalclaims@medmal.com**

Phone: (516)-277-4194
Fax # (516) 684-2359

From: Name of Facility/Insured:_____ Facility Phone #: _____

Facility Fax:_____ Policy #: _____

Facility/Site Address:_____

Date: _____

Re: Reporting of (PLEASE CHECK ONE)

☐ *incident/record request* ☐ *claim* ☐ *subpoena* ☐ *summons* ☐ *other*

Patient/Claimant Name:_____ Marital Status _____

Patient/Claimant's spouse/parent/guardian (if any): _____

Date of birth/age: _____ Medical record #: _____

First date of treatment: _____ Last date of treatment: _____

Date of occurrence/incident: _____ Place of occurrence/incident: _____

Description of occurrence/incident:

_____

_____

_____

_____

_____

_____

Identify involved parties named in **summons** or subpoena and relationship to insured facility. If employed, please indicate whether additional insured on the facility's policy and complete dates of employment:

Name of Defendant	Clinical Dept.	Date Served	Relationship to Facility

List Attachments:

☐ copy of occurrence/incident report/record request ☐ original summons & complaint
☐ original subpoena ☐ copy of attorney and/or claimant letter ☐ other _____

"ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON, FILES A STATEMENT OF CLAIMS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION."

Signature of person completing report: Date:

_____ _____

Name of person completing report (please print):

_____

Title:

_____