1800 Northern Blvd., P.O. Box 9007
Roslyn, NY 11576
(516) 365-6690
(800) 632-6040
PRI.com

Healthcare Facility Claims Reporting Process

All Incidents, Claims, and Suits are to be reported to:

E-mail: prihospitalclaims@medmal.com
(Healthcare Facility Claims Mailbox)

Address: Physicians' Reciprocal Insurers
1800 Northern Boulevard
Roslyn, NY 11576

Fax: (516) 684-2362

Contact: Marianna Dimoski, Director, Claims
Telephone: (516) 277-4194

Claim(s)/Summons(es): Please include a copy of the Claim letter or Summons and Complaint, along with the attached form, "Healthcare Facility Report of Incident/Claim/Subpoena/Summons." The attached form should be completed in its entirety.

Incident(s): Please include a copy of any incident report, New York Patient Occurrence Reporting and Tracking (NYPORTS) report, patient or attorney request letter for medical records, or other relevant correspondence, along with the attached form "Healthcare Facility Report of Incident/Claim/Subpoena/Summons." The attached form should be completed in its entirety.

Types of Incidents to report: Any occurrence out of the normal course of treatment for the patient should be reported to Physicians' Reciprocal Insurers. Possible 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 or wrong side surgery, medication errors, slips/falls, IV infiltrates, unexpected deaths, failure to diagnose, and/or incorrectly interpreted radiological imaging, labs, etc.

Notification to Client: You will be notified in writing by the assigned claims representative once a file has been established. Please forward complete copies of the patient's medical records to the assigned claims representative once you have received notice from them. Radiological imaging should be submitted in digital format.

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(Healthcare Facility Claims Mailbox)
Fax: (516) 684-2362

Contact: Marianna Dimoski, Director, Claims
Telephone: (516) 277-4194

Name of Facility/Insured:_____ Policy #: _____

Facility Phone #: _____ Facility Fax #: _____ Facility E-mail: _____

Facility/Site Address: _____

Date: _____

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:

_____

_____

_____

_____

_____

_____

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Identify involved parties named in summons or subpoena and relationship to insured facility. If employees of the insured facility, 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**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Check 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 an application for insurance or statement of claim 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:

_____ _____

Printed Name of person completing report:

_____

Title:

_____