

Hospital Program Loss Advice Form

Claim Number: _____ Policy Number: _____

Policy Period: _____ Retro Date: _____

Type of Medical Incident/Loss: HPL GL Date of Medical Incident/Loss: _____

Claimant: _____

Age: _____ Date of Birth: _____ Occupation: _____

Annual Salary: \$ _____ Sex: M F

Marital Status: Single Married Divorced Widowed

Dependants: Name and Age

Date Reported to Risk Manager: _____

First Reported to Risk Manager by:

- Commencement of suit
- Written demand for compensation
- Medical record request
- Letter of representation
- Verbal notice from physician
- Verbal notice from nurse/other
- Internal incident form
- QA/UR referral
- Patient grievance
- Other; Specify: _____

Reported to ProAssurance Mid-Continent as:

- Suit Date Suit Filed: _____ Jurisdiction (enclose suit papers): _____
- Written Demand for Compensation or Services (enclose demand for compensation or services)
Date of Demand: _____
- Circumstance (enclose any internal reports)

Unit Involved:

- | | |
|--|---|
| <input type="checkbox"/> Anesthesia | <input type="checkbox"/> Burn Unit |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Emergency Department |
| <input type="checkbox"/> Gynecology | <input type="checkbox"/> ICU |
| <input type="checkbox"/> IV Therapy | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Neonatal ICU |
| <input type="checkbox"/> Nursery | <input type="checkbox"/> Obstetrics |
| <input type="checkbox"/> Operating Room | <input type="checkbox"/> Out-Patient Clinic |
| <input type="checkbox"/> Pathology | <input type="checkbox"/> Pediatrics |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Radiation Therapy | |
| <input type="checkbox"/> Other; Specify: _____ | |

