

## **Healthcare Facility Claims Reporting Process**

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

**E-mail:** hospitalclaims@medmal.com

(Healthcare Facility Claims Mailbox)

**Address:** EmPRO Insurance

1800 Northern Boulevard

Roslyn, NY 11576

**Fax:** (516) 684-2362

**Contact:** Marianna Dimoski, Director, Claims

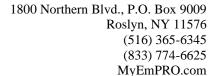
Telephone: (516) 277-4194

<u>Claim(s)/Summons(es):</u> 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.

<u>Incident(s)</u>: 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 EmPRO Insurance Company. 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.

<u>Notification to Client:</u> 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.





## Healthcare Facility Report of Incident/Claim/Subpoena/Summons

## Please submit completed form to: **E-mail:** hospitalclaims@medmal.com Contact: Marianna Dimoski, Director, Claims (Healthcare Facility Claims Mailbox) **Telephone:** (516) 277-4194 Fax: (516) 684-2362 Name of Facility/Insured:\_\_\_\_\_\_Policy #: \_\_\_\_\_ Facility Phone #: \_\_\_\_\_ Facility Fax #: \_\_\_\_\_ Facility E-mail: \_\_\_\_\_ Facility/Site Address: Date: Reporting of (Please check one) ☐ *Incident/Record request* $\square$ Summons $\square$ Other □ Claim □Subpoena 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:



1800 Northern Blvd., P.O. Box 9009 Roslyn, NY 11576 (516) 365-6345 (833) 774-6625 MyEmPRO.com

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.	<b>Date Served</b>	Relationship to Facility
Check Attachments:			
☐ Copy of Occurrence/In	cident Report/Record R	equest	ginal Summons & Complaint
☐ Original Subpoena ☐	Copy of Attorney and/o	or Claimant Letter	Other
be subject to a cive claim for each su  Signature of person comple	ch violation.		nd the stated value of the  Date:
Printed Name of person co	ompleting report:		
Title:			