



## CLAIMS REPORTING PROCESS

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

**Hospital Claims Mailbox: [emprohospitalclaims@medmal.com](mailto:emprohospitalclaims@medmal.com)**

**David Haug, Claims Process Supervisor  
Telephone: (516) 277-4194**

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

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

**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 EmPRO. 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 interrupted 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: EmPRO – Claims Dept.
Email: emprohospitalclaims@medmal.com

Fax # (516) 684-2362

EmPRO Claims Reporting contact:

David Haug, Claims Process Supervisor
(516) 277-4194

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:

Multiple horizontal lines for text entry.

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 |
|-------------------|----------------|-------------|--------------------------|
| _____             | _____          | _____       | _____                    |
| _____             | _____          | _____       | _____                    |
| _____             | _____          | _____       | _____                    |
| _____             | _____          | _____       | _____                    |

**Requested Defense Counsel:**

Assign File to: \_\_\_\_\_ Att: \_\_\_\_\_

**List Attachments:**

- copy of occurrence/incident report/record request
- original summons & complaint
- original subpoena
- copy of attorney and/or claimant letter
- Other \_\_\_\_\_

Name of person completing report (please print):

\_\_\_\_\_

Title:

\_\_\_\_\_

Signature of person completing report:

\_\_\_\_\_

Date:

\_\_\_\_\_

“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.”