Instructions for Completion of Verification Forms

- When the statutory primary indemnity aggregate becomes eroded by 50% or more, please complete the information requested in each section of the Verification Form.

- If the claim is not in suit, please note that in the “Full Case Caption” block and report “N/A” in the “Venue/Docket” space.

- The Mcare Fund will review the submitted Verification Form(s) and notify the submitting Contact Person of any questions.

Any questions concerning the completion of the Verification Form should be directed to Carole Z. Strickland, Claims Manager, at the address and telephone number on the top of the Verification Form.

PA Insurance Department

Office of Medical Care Availability and Reduction of Error Fund

Return Form to: 1062 Lancaster Avenue, Suite 15-F
Rosemont, PA 19010
Tel: 610-801-2200 Fax: 610-801-2211

Verification Form

Exhaustion of Primary Aggregate Limits

Health Care Provider Name & Current Address

____
____
____
____

Primary Carrier or Self-Insured

____

PA License No.

____

Coverage Period Impaired

___/___/____ to ___/___/____

Coverage Type

- ☐ Occurrence
- ☐ Claims-Made
- ☐ Tail
- ☐ Prior Acts
- ☐ Other, please specify

Paid Claim Information

1 Claim Per Form

Full Case Caption:

Mcare File #:

Occurrence Date:

Claims Made Date:

Venue/Docket #:

Date of Settlement/Judgment:

Primary Information

Date of Primary Payment	Amount of Primary Payment
	$

Brief Factual Summary of Case:

Contact Person:

Telephone No: Ext:

Form Completion Date