MEDICAL CARE AVAILABILITY AND REDUCTION OF ERROR FUND
CLAIM REPORT BY INSURER OR SELF-INSURER

1a. Insurer's or Self-Insurer's Name & Address:	**1b. Claim File #:** **Policy #:** **Policy Type: CM____ OC____ OP____ PA____ RE____ TA____** **Policy Effective Dates:** **Primary Policy Limit:**
2a. Health Care Provider's Full Name, Employer's Name & Address:	**2b. Date of Birth:** **PA License #:** **Professional School:** **Year of Graduation:**
3a. Claimant's (Injured Person) Full Name & Address:	**3b. Date of Birth (or age at time of incident):** **Occupation:**
4a. Starting Date of Alleged Malpractice: **Ending Date of Alleged Malpractice:** **Excess____ Section 605/715____ Drop Down____**	**4b. Date Claim First Reported to Insured:** **Date Claim First Reported to Insurer:** **Date of Serious Event Notification to Claimant:** **Date Suit Filed/Demand for Damages (whichever is earlier):**
5. Place Injury Allegedly Occurred:	
6a. Severity of Injury (mandatory-use numerical codes in Claim Reporting Guidelines):_____ **6b. Nature of Treatment Giving Rise to Claim, including Principal Injury Alleged (attach statement of facts, if desired):**	
7. Claimant's Present Condition and Prognosis:	
8. Additional Defendants:	**Additional Defendants' Insurers (if known):**
9. Plaintiff's Attorney (Name, Address & Phone #):	
10. Defense Attorney (Name, Address & Phone #):	
11. Insurer's Claim Reserve:	
12. **Preparer's Name** **Preparer's E-Mail Address** _____ _____ **Preparer's Title** **Phone Number** _____ _____-_____-_____ ext. _____ _____/_____/_____ **Preparer's Signature** **Date**	

NOTE: PLEASE FOLLOW CLAIM REPORTING GUIDELINES, AND NOTE THAT IF MANDATORY BLOCKS ARE NOT COMPLETED, FORM WILL BE RETURNED.