



Physician Name: _____

CLAIM INFORMATION

Patient Name: _____ Date of Treatment: ____/____/____

Summary of the medical facts, including the allegations:

Status of Claim/Disposition/Suit

Open Closed—with NO Payment Date: ____/____/____ Closed—with PAYMENT Date: ____/____/____
Your Policy \$ _____

Attach supplemental claims information if necessary Total (if other defendants involved) \$ _____

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Your Policy \$ _____

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TYPE OF PRACTICE

- 1. Do you Practice as an Individual (solo practice)? Yes No
- 2. Employee? Yes No Name of Employer: _____
- 3. Independent Contractor? Yes No
- 4. Do you Practice in a Group?: Yes No Number of Physician's in Group: _____
- 5. Name of Group Practice: _____
- 6. Partner/Shareholder? Yes No
- 7. Names of physicians in group:

8. Names of any employed physicians/ancillary personnel:



Upon completion of this form, attach a copy of your current policy's Declarations* page and return to
MEDICAL RISK SERVICES, INC. — FAX #630-821-6001
 (*The declarations page is usually the first policy page, containing the limits, retroactive date, specialty code, premium etc.)