Risk Transfer Insurance Alliance

Claim Report

INSURED INFORMATION

Name: ______________________ Account #: ______________________

Employer: ______________________ Policy #: ______________________

Address: ______________________ Policy Period: ______________________

______________________ Agent: ______________________

______________________ ______________________

Business Phone: ______________________ Home Phone: ______________________

PATIENT INFORMATION

Name of Patient/Claimant: ______________________
(First) (MI) (Last)

Address: ______________________ Telephone: ______________________

______________________ Date of birth: ______________________

______________________ SSN: ______________________

Has this been previously reported? If so, please provide incident #: ______________________

Date of Incident (If unknown, give treatment dates): ______________________

Description of Incident or Treatment: ______________________

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Injuries(if Known): ______________________

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THIS IS BEING REPORTED FOR:

- ☐ Informational purposes only
- ☐ Deposition only (please attach)
- ☐ Formal claim (claim letter - please attach)
- ☐ Medical record request (please attach)
- ☐ Formal claim (summons and complaint - please attach)

DEPOSITION ONLY

Defense Attorney Preference: ______________________

SUMMONS AND COMPLAINT

Date of Service: ______________________

Defense Attorney Preference: ______________________

ADDITIONAL COMMENTS

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Report Completed by: ______________________ *Date:* ______________________

Please return to: **Risk Transfer Insurance Alliance, LLC**
175 Federal Street, Suite 725
Boston, MA 02110-2202
Fax: 617-423-7541

Revision date: 07/02/2006