# Medical Alliance Insurance Company

## Notice of Claim

To: Claims Department/MAIC
c/o Illinois Risk Management Services
1151 East Warrenville Rd. P. O. Box 3015
Naperville, IL 60566
Telephone : 630/ 276-5857 Fax: 630/ 717-4776

**Instructions:**

Please complete all the information requested to the best of your ability. You may mail or fax the Notice of Claim to the above address. In the event you desire to receive further information concerning a patient complaint or you wish to speak directly with a Claims Supervisor, please call the Claims Department and ask to speak to a professional liability Claims Supervisor.

If you have any questions concerning execution of this form or wish to report by telephone, please call a MAIC Claims Supervisor. If you know the name of the Claims Supervisor assigned to your policy, request information from that supervisor. Be prepared to provide the Claims Supervisor with the information requested in this form.

1. Date of Notice: _____

2. Physician/Policy holder's name:_____

3. Address:_____

4. Telephone number to contact you: Office:_____

   Home (optional)_____

5. Policy Number:_____

6. Name of claimant/patient:_____

7. Patient's address:_____

8. Patient's telephone number:_____

9. Reason for sending Notice of Claim. Please check appropriate box:

☐ Patient Complaint ☐ Event Only (a claim has not been asserted but could develop

☐ Summons & Complaint ☐ Attorney letter/lien/contact

10. If a Summons & Complaint was served on you, give a date of service:_____

11. Date(s) of treatment upon which claim is based:_____

12. Briefly describe the facts giving rise to the claim: (if more space is necessary, provide further information on a separate page).

_____
_____
_____
_____

13. Is the patient/claimant still being treated by your office? Yes No

14. What is the balance of the patient's bill with your office? $_____

15. If this claim arose because of an event occurring at a hospital, state the name of the involved hospital: _____

16. What is the best time and day to contact you?_____a.m./p.m., on _____(day)

17. If there is some other person in your office who can be contacted regarding this claim, please state the name of that person:_____

18. Attach any correspondence from the patient/claimant or patient/claimant's attorney, including Summons & Complaint. Do not send copies of office records at this time.

**NOTE:** A claim representative from our office may contact you to obtain more detailed information regarding this claim. Please cooperate with our claims representative.

Do not provide any information regarding this claim to any person other than our authorized claim representative or the legal counsel we may assign to represent you in the event you are named as a defendant in a lawsuit.

Do not **under any circumstances,** destroy any information, notes, or records of any nature that might even be remotely related to this claim.

Do not make any alterations, additions, comments, modifications, or changes of whatever nature to your medical or office records regarding this claim. Contact our office if you have any questions concerning appropriateness of documentation of any medical records.

_____ _____

Physician/Policyholder (signature) Date

**4/13**