DOCTORS' ARMOR
by Physicians Indemnity

Confidential Incident Report Form

Date of Submission _____

POLICYHOLDER INFORMATION

Name of Insured	
Policy Number	
Insured Contact Information	
Telephone – Home	
Telephone – Office	
Telephone – Cellular	
Email Address	
Insured(s) / Additional Insured(s) Involved (please include contact information)	

CLAIMANT INFORMATION

Claimant Name							
Claimant Address							
Date of Birth							
Gender	☐	Male		☐	Female		
Marital Status	☐	Single	☐	Married	☐	Divorced	
Social Security Number							
Medicare Recipient ID No (if applicable)							
Date(s) of Incident / Treatment							
Location of Incident / Treatment							

CLAIM INFORMATION

	Type of Claim	Date Received by Insured (*required information)*
☐	Contacted by Client	
☐	Unasserted Potentially Compensable Event	
☐	Medical Records Request (Non-Attorney)	
☐	Medical Records Request (Attorney)	
☐	Letter of Intent / Verbal Request for Compensation	
☐	Lawsuit	
	Date Insured Served	
	Date Filed with Court	

PLEASE ATTACH ALL CORRESPONDENCE, LEGAL PAPERS SERVED UPON INSURED, SUBSTANTIVE MEDICAL RECORDS, AS WELL AS THE POLICY OF INSURED AND ALL ENDORSEMENTS TO THE POLICY

DESCRIPTION OF INCIDENT / TREATMENT *(Please include symptom(s), nature of care provided, final outcome, etc.)*

Any known hostility / threats of litigation by patient, patient's family and/or friends? If so, please explain.

Form submitted by	
Email Address / Telephone Number	

Submit form (with attachments) via email to
Steve Adler (sadjuster1@aol.com) and info@pirrg.com
Please contact our office with any questions – 813-513-3041