Kaleida Health

PROFESSIONAL LIABILITY CLAIMS INFORMATION FORM ☐ NONE

The following information is necessary to complete the credentialing verification process and will be kept confidential. Please PRINT or TYPE answers to the following for any malpractice claims reported to your malpractice insurance carrier, opened, closed, settled or paid. Please complete a separate form for each professional liability claim. Only list one case per sheet. (You may photocopy if additional sheets are needed.)

PROVIDER'S NAME				
NAME OF PATIENT INVOLVED	AGE	MONTH/YEAR OF OCCURRENCE	MONTH/YEAR OF LAWSUIT	INSURANCE CARRIER AT TIME

WHAT IS/WAS YOUR STATUS? ☐ Primary Defendant ☐ Co-Defendant ☐ Other, please explain:	LIST OTHER DEFENDANTS

WHAT WAS THE PATIENT'S OUTCOME?
HOW WERE YOU ALLEGED TO HAVE CAUSED HARM OR INJURY TO THE PATIENT?
PLEASE PROVIDE SPECIFICS IN REFERENCE TO THE ADVERSE EVENT
WHAT IS/WAS YOUR ROLE IN THIS EVENT?

CURRENT STATUS		
☐ Still Pending	Who is handling the defense of the case?	
☐ Trial date set (awaiting trial) – Date_____		
☐ Dismissed – Date_____		
☐ Defense Verdict – Date_____		
☐ Settled out of court – Date_____	Total Amount of Settlement $	Amount Paid by You $
☐ Judgment – Date_____	Total Amount of Judgment $	Amount Paid by You $

This Professional Liability Claim Information Form is required on all claims/lawsuits that are reported by your malpractice carrier and/or the National Practitioner Data Bank. Clinical details are required for all suits, regardless of status or settlement amount.

I certify that the information contained in this form is correct and complete to the best of my knowledge.

Signature: "**Applicant must use Signature Attestation form at the end of the electronic application in order to sign/date this form**"	Date