# YELLOWSTONE REPORT OF CLAIM FORM

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***CONFIDENTIAL: Prepared in Anticipation of Litigation***

**Health Care Entity*:** _____ Department: _____

Name: _____ Inpatient: ☐ Employee: ☐

**DOB*:** _____ Sex: _____ Outpatient: ☐ Other: ☐

Marital Status: _____ Visitor: ☐

Address: _____ **Social Security #*:** _____

Telephone Number: _____

Billing Status (Health Insurance, Outstanding Hospital Bills): **Medicare Patient*:** Yes ☐ No ☐

_____ **Medicare #*:** _____

Dates of Treatment: _____ Date/Time of Incident: _____

Date Reported to RM: _____ How Reported: _____

| | | | |
|---|---|---|---|
| Was Occurrence Report Filed? | Yes ☐ | No ☐ | Date: _____ |
| Prelitigation Panel Hearing Request? | Yes ☐ | No ☐ | Date: _____ |
| Complaint Served? | Yes ☐ | No ☐ | Date: _____ |
| Prior Telephone Notification to Yellowstone? | Yes ☐ | No ☐ | Date: _____ |

Hospital Staff Involved: _____

Description:

_____

Injury: _____

Analysis of Factors Contributing to the Event:

_____

Documents to Follow:

| | | | |
|---|---|---|---|
| Panel Hearing Request: | ☐ | Attorney Letter: | ☐ |
| Suit Papers: | ☐ | Medical Records: | ☐ |
| Claimant Letter: | ☐ | How Reported: | _____ |

| **Physicians Involved** | **Specialty** | **Insurance Carrier** | **Limits** |
|---|---|---|---|
| | | | |
| | | | |

Recommendations: Precautionary-Incident Only ☐ Claim ☐ Suit ☐

Additional Comments:

_____

Prepared By: _____ Date: _____

***Required Field**

YELLOWSTONE INSURANCE EXCHANGE, RRG

**(Revised 04/10)**