

Healthcare Services Group Claim or Medical Incident Report

Date:	Policy Number:
Insured Name:	
Office Address:	
Office Phone Number:	Contact Person:
If you prefer to be contacted at home	
Home Address:	
Home Phone Number:	

Date of medical care which resulted in claim or medical incident:
Patient's Name:
Discuss the reason why claim made by patient or patient's family or why this may result in future claim. (e.g. alleging failure to diagnose, adverse outcome, further complications, not satisfied with bill considering outcome, etc.)

With this report, enclose a copy of all medical records and any correspondence received from this patient or their representative. If they are voluminous, call us to determine what should be done about providing copies to us or our investigators or attorneys.

Send by Certified Mail to: Claim Department
 Healthcare Services Group
 PO Box 1498
 Jefferson City, MO 65102-1498
 800-234-2297