

REPORT INPUT FORM

Medical Malpractice Payment Report**Individual Subject: Initial Report**

Please provide as much of the following information as possible. Failure to provide sufficient information to permit identification of a single subject will result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0126 expiration date 12/31/13

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 45 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

PRACTITIONER INFORMATION[Help ?](#)**Personal Information****Practitioner Name**

Last Name	First Name	Middle Name	Suffix (Jr, III)
<input type="text" value="SMITH"/>	<input type="text" value="JOHN"/>	<input type="text"/>	<input type="text"/>

[Add another name used](#)

Is Subject Deceased?

No Unknown Yes

Gender

Male Female Unknown

Birth Date (MMDDYYYY)**Home Address/Address of Record**

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

Country:
(if U.S., leave blank)

Work Information

Check here if the practitioner's work information is the same as your organization.

Organization

Name:

Click [Help ?](#) for information on filling out non-U.S. and military addresses.

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

Country:
(if U.S., leave blank)

Social Security Numbers (SSN)

[Add another SSN](#)

Drug Enforcement Administration (DEA) Numbers

[Add another DEA Number](#)

Professional Schools Attended

The form will suggest schools as you type. Please choose the matching school or enter the complete school name.

Year of

School Name:

Graduation (YYYY)

[Add another](#)

[Professional School](#)

Occupation And State Licensure Information

(Provide at least one license. Check 'No License' if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

1. State License Number: OR No License

State of Licensure:

Occupation/Field of Licensure:

[Add Additional License/Occupation](#)

Hospital Affiliation(s)

Name City State

[Add another Hospital Affiliate](#)

Payments by This Payer for This Practitioner

Amount of This Payment for This Practitioner: \$
(Format NNNNN.NN)

Date of This Payment:
(MMDDYYYY)

This Payment Represents: A Single Final Payment
 One of Multiple Payments

Total Amount Paid or to Be Paid by This Payer for This Practitioner: \$
(Format NNNNN.NN)

Payment Result of: Judgment
 Settlement
 Payment Prior to Settlement

Date of Judgment or Settlement:
If any (MMDDYYYY)

Adjudicative Body Case Number:
(If applicable)

Adjudicative Body Name:
(If applicable)

Court File Number:
(If applicable)

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

There are **4000** characters remaining for the description.

Spell Check

Payments by This Payer for Other Practitioners in This Case

Total Amount Paid or to Be Paid by This
Payer for All Practitioners in This Case: \$

(Format NNNNN.NN)

(Including the Amount Specified Above for
This Practitioner)

Number of Practitioners for Whom This
Payer Has Paid or Will Pay in This Case:

Payment Information

Relationship of
Entity to This
Practitioner:

CHOOSE ONE FROM LIST



Classification of Act(s) or Omission(s)

Patient Information

Patient's Age at Time of Initial Event:

- Days (if less than 1 month)
- Months (if less than 1 year)
- Years
- Unknown

Patient's Gender:

- Male
- Female
- Unknown

Patient Type:

- Inpatient
- Outpatient
- Both
- Unknown

Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation)

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

There are **4000** characters remaining for the description.

Spell Check

Description of the Procedure Performed

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

There are **4000** characters remaining for the description.

Spell Check

Allegation

Nature of Allegation:

Specific Allegation:

Date of Event Associated With Allegation or Incident:
(MMDDYYYY)

[Add another Allegation](#)

Outcome

Outcome:

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

There are **4000** characters remaining for the description.

[Spell Check](#)

Entity Internal Report Reference

This optional field allows your entity to include an internal file number or other reference information to help you identify this report in your files. This information is not used by the Data Bank, but it will be provided on copies of the report sent to queriers.

Entity Internal Report Reference:
(e.g., claim number)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

- Send e-mail notification when this and any future responses are available.
- Check this box if you wish to add/update this subject in your subject database for use in future queries and/or reports. Duplicate entries in your subject database may result in duplicate queries. You will be notified of potential duplicate entries prior to completing this subject entry.

[Help ?](#)

[Continue](#)

[Validate Without Submitting](#)

[Store as a Draft](#)

[Return to Options](#)

REPORT INPUT FORM

Medical Malpractice Payment Report Report Correction

To submit a **correction** to previously submitted report DCN 7930000076906092, complete all necessary modifications in the form below, and press **Submit to Data Bank**.

The report entered here will replace the original report, so please ensure that all known data is entered in its entirety. Failure to provide sufficient information to permit identification of a single subject may result in the report being rejected, necessitating resubmission.

Do not print this page. A printable copy of your report submission will be provided after submission.

OMB # 0915-0126 expiration date 12/31/13

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0126 (NPDB). Public reporting burden for this collection of information is estimated to average 15 minutes to complete the forms, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14-22, Rockville, Maryland, 20857.

PRACTITIONER INFORMATION

[Help ?](#)

Personal Information

Practitioner Name

Last Name	First Name	Middle Name	Suffix (Jr, III)
<input type="text" value="SMITH"/>	<input type="text" value="JOHN"/>	<input type="text"/>	<input type="text"/>

[Add another name used](#)

Is Subject Deceased?

No Unknown Yes

Gender

Male Female Unknown

Birth Date (MMDDYYYY)

Home Address/Address of Record

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

Country:

(if U.S., leave blank)

Work Information

Check here if the practitioner's work information is the same as your organization.

Organization

Name:

Click  for information on filling out non-U.S. and military addresses.

Address

Street Address:

Address Line 2:

City:

State:

ZIP Code: -

Country:

(if U.S., leave blank)

Social Security Numbers (SSN)

[Edit](#)
[Add another SSN](#)

Drug Enforcement Administration (DEA) Numbers

[Add another DEA Number](#)

Professional Schools Attended

The form will suggest schools as you type. Please choose the matching school or enter the complete school name.

School Name:
[Professional School](#)

Year of Graduation (YYYY) [Add another](#)

Occupation And State Licensure Information

(Provide at least one license. Check 'No License' if the subject does not have a State License Number. Use the **Add Additional License/Occupation** button to provide more than one license. Up to 60 licenses may be provided.)

1. State License Number: OR No License

State of Licensure:

Occupation/Field of Licensure:

[Add Additional License/Occupation](#)

Hospital Affiliation(s)

Name City State

[Add another Hospital Affiliate](#)

Payments by This Payer for This Practitioner

Amount of This Payment for This Practitioner:
(Format NNNNN.NN)

Date of This Payment:
(MMDDYYYY)

This Payment Represents: A Single Final Payment
 One of Multiple Payments

Total Amount Paid or to Be Paid by This Payer for This Practitioner:
(Format NNNNN.NN)

Payment Result of: Judgment
 Settlement
 Payment Prior to Settlement

Date of Judgment or Settlement:
If any (MMDDYYYY)

Adjudicative Body Case Number:
(If applicable)

Adjudicative Body Name:

(If applicable)

Court File Number:
(If applicable)

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

DESCRIPTION

There are **3989** characters remaining for the description.

Spell Check

Payments by This Payer for Other Practitioners in This Case

Total Amount Paid or to Be Paid by This
Payer for All Practitioners in This Case: \$

(Format NNNNN.NN)

(Including the Amount Specified Above for
This Practitioner)

Number of Practitioners for Whom This
Payer Has Paid or Will Pay in This Case:

Payment Information

Relationship of
Entity to This
Practitioner:

Insurance Company - Primary Insurer



Payments by Others for This Practitioner

Complete if your entity is an Insurance Company or a Self-Insured Organization. Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?:

- Yes
- No
- Unknown

Complete if your entity is an Insurance Company, an Insurance Guaranty Fund or a State Medical Malpractice Payment Fund. Has a Self-Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such

Payment(s) Expected to Be Made?:

- Yes
- No
- Unknown

Classification of Act(s) or Omission(s)

Patient Information

Patient's Age at Time of Initial Event:

- Days (if less than 1 month)
- Months (if less than 1 year)
- Years
- Unknown

Patient's Gender:

- Male
- Female
- Unknown

Patient Type:

- Inpatient
- Outpatient
- Both
- Unknown

Description of the Medical Condition With Which the Patient Presented for Treatment (Prior to the Event That Led to the Malpractice Allegation)

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

DESCRIPTION OF THE MEDICAL CONDITION

There are **3964** characters remaining for the description.

Spell Check

Description of the Procedure Performed

Note: Do not reference any personal identification information (e.g., names) of anyone other

than the subject of this report.

DESCRIPTION OF THE PROCEDURE PERFORMED

There are **3962** characters remaining for the description.

Spell Check

Allegation

Nature of Allegation:

Specific Allegation:

Date of Event Associated With Allegation or Incident:
(MMDDYYYY)

[Add another Allegation](#)

Outcome

Outcome:

Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based

Note: Do not reference any personal identification information (e.g., names) of anyone other than the subject of this report.

DESCRIPTION OF THE ALLEGATIONS AND INJURIES OR ILLNESSES
UPON WHICH THE ACTION OR CLAIM WAS BASED

There are **3903** characters remaining for the description.

Spell Check

Entity Internal Report Reference

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Entity Internal Report
Reference:
(e.g., claim number)

Customer Use

This optional field may be used by the submitter to identify this transaction. This information is returned without modification and only appears on the response returned to your organization.

Customer Use:

Send e-mail notification when this and any future responses are available.

Continue

Validate Without Submitting

Store as a Draft

Return to Options