REPORT INPUT FORM

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

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)
SMITH	JOHN		

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: CHOOSE ONE FROM LIST

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: CHOOSE ONE FROM LIST

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: CHOOSE ONE FROM LIST

Occupation/Field of Licensure: Physician (MD)

Add Additional License/Occupation

Hospital Affiliation(s)

Name City State CHOOSE ONE FROM LIST

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: CHOOSE ONE FROM LIST

Specific Allegation: CHOOSE ONE FROM LIST

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

Add another Allegation

Outcome

Outcome:

CHOOSE ONE FROM LIST

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

the DataBank
NATIONAL PRACTITIONER
HEALTHCARE INTEGRITY & PROTECTION

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)
SMITH	JOHN		

Add another name used

Is Subject Deceased?

(•) No ( ) Unknown ( ) Yes

Gender

(•) Male ( ) Female ( ) Unknown

Birth Date (MMDDYYYY)

05051950

Home Address/Address of Record

Street Address: 123 FAKE STREET

Address Line 2:

City: FAIRFAX

State: VA Virginia

ZIP Code: 20120 -

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: CHOOSE ONE FROM LIST

ZIP Code: -

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

Social Security Numbers (SSN)

*****1234 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.

COLLEGE UNIVERSITY 2000

School Name:

Year of 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: 123 ABC OR ☐ No License

State of Licensure: AK Alaska

Occupation/Field of Licensure: Physician (MD)

Add Additional License/Occupation

Hospital Affiliation(s)

Name | City | State: CHOOSE ONE FROM LIST

Add another Hospital Affiliate

Payments by This Payer for This Practitioner

Amount of This Payment for This Practitioner: (Format NNNNN.NN) $ 500.00

Date of This Payment: (MMDDYYYY) 02022013

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) $ 500.00

Payment Result of:
- ( ) Judgment
- (•) Settlement
- ( ) Payment Prior to Settlement

Date of Judgment or Settlement: If any (MMDDYYYY) 02022013

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: 010 Anesthesia Related

Specific Allegation: 100 Failure to Use Aseptic Technique

Date of Event Associated With Allegation or Incident: (MMDDYYYY) 01012013

Add another Allegation

Outcome

Outcome:

01 Emotional injury only

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