Medical Malpractice Pay

TITIONER DATA BANK
PDB

burden statement

1. Subject Information

Please fill ou

Personal Informa

Last Name

Last Name

+ Additional name (

Public Burden Statement

OMB # 0915-0126 expiration date MM/DD/YY

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. Public reporting burden for this collection of information is estimated to average 45 minutes to complete this form, 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 14N-39, Rockville, Maryland, 20857.

Close

Medical Malpractice Payment Report: Initial Report

NATIONAL PRACTITIONER DATA BANK
NPDB

Public burden statement

1. Subject Information

Please fill out as much information as possible to help entities find your report when they query.

Personal Information

Last Name | **First Name** | **Middle Name** | **Suffix (Jr, III)**

Last Name | First Name | Middle Name | Suffix

+ Additional name (e.g. maiden name)

Gender

○ Male ○ Female ○ Unknown

Birthdate

MM-DD-YYYY

Is this person deceased?

○ No ◉ Yes ○ Unknown

Date of Death

MM-DD-YYYY

Home Address/Address of Record

Country

United States

Address Entering a military address?

Address

Address Line 2

Apt, Floor, Room, Suite, etc. (Optional)

City | **State**

City

ZIP

ZIP

+ Additional address

Work Information

☐ Use our information as the practitoner's work information.

Organization Name

Organization Name

Organization Type

Other Type - Not Classified, Specify

Organization Description

Organization Description

Country

United States

Address Entering a military address?

Address

Address Line 2

Apt, Floor, Room, Suite, etc. (Optional)

City | **State**

City

ZIP

ZIP

Profession and Licensure

License 1

Profession or Field of Licensure | **Specialty**

Select One

Does the subject have a license for the selected profession or field of licensure?

◉ Yes ○ No / Not sure

License Number | **State**

CHOOSE ONE FROM LIST

+ Additional license

Professional Schools Attended

Enter the schools or institutions the practitioner attended for their professional degree, training or certification (e.g. medical school, certification program). If the practitioner attended medical school, enter the medical school first, then add the school where they completed their residency and other degrees.

What if the practitioner has not graduated?

Name of School or Institution | **Completion Year**

School Name | YYYY

+ Additional school or institution

Identification Numbers

SSN or ITIN (Social Security Number or Individual Taxpayer Identification Number)

SSN or ITIN

+ Additional SSN or ITIN

NPI (National Provider Identifier)

To help queriers find your report, add the practitioner's NPI number if you know it.

NPI

+ Additional NPI

DEA (Drug Enforcement Agency) Number

DEA

+ Additional DEA

☑ Does the subject have an FEIN or UPIN identification number?

FEIN (Federal Employer Identification Number)

FEIN

+ Additional FEIN

UPIN (Unique Physician Identification Numbers)

UPIN

+ Additional UPIN

Hospital Affiliation

Hospital Name

Hospital Name

City | **State**

City

+ Additional hospital

☐ Add this subject to my subject database
What is a subject database?

Save and finish later | Continue to next step

2. Action Information

3. Review

4. Certifier Information

Return to Options

Select an Occupation or Field of Licensure

Enter a keyword or phrase to find matching occupations. (Example: "counselor")

Search

Physician

- Physician (MD)
- Physician Resident (MD)
- Osteopathic Physician (DO)
- Osteopathic Physician Resident (DO)

Nurse - Advanced, Registered, Vocational or Practical

- Registered Nurse
- Nurse Anesthetist
- Nurse Midwife
- Nurse Practitioner
- Licensed Practical or Vocational Nurse

Don't see what you're looking for?

Medical Malpractice Payment Report: Initial Report

NATIONAL PRACTITIONER DATA BANK
NPDB

Public burden statement

1. Subject Information — Edit

2. Action Information

Payment for This Practitioner

Amount of this payment

$ 0000.00

Date of this payment

MM-DD-YYYY

This payment represents

○ A single final payment ◉ One of multiple payments

Total amount paid (or to be paid)

$ 0000.00 ☑ Unknown

This payment was a result of:

Judgment

Date of the Judgment

MM-DD-YYYY

Adjudicative Body Name

Adjudicative Body Name

Case Number

Case Number

Court File Number

Court File Number

Describe the judgment including any conditions or terms of payment.

Do not include any personally identifying information, such as names, for anyone other than this practitioner.

Your narrative description helps querying organizations understand more about the payment and why it was made.

4000 characters remaining

Payment for Other Practitioners

Are other practitioners included in this case?

◉ Yes ○ No

Total number of practitioners

Total amount paid (to be paid) by this payer for all practitioners

$ 0000.00

Payment Information

Your organization's relationship with this practitioner

Insurance company - primary insurer

Payment by Other Organizations

Has a state guaranty fund or state excess judgment fund made a payment for this practitioner in this case (or is such payment expected to be made)?

◉ Yes ○ No ○ Unknown

Total amount paid (or to be paid)

$ 0000.00

Has a self-insured organization and/or other insurance company/companies made payment(s) for this practitioner in this case (or is such payment expected to be made)?

◉ Yes ○ No ○ Unknown

Total amount paid (or to be paid)

$ 0000.00

Acts or Omissions

Patient's age at the time of the initial event

0 Days ☐ Unknown

Patient's Gender

○ Male ○ Female ○ Unknown

Type of Care

○ Inpatient ○ Outpatient ○ Both ○ Unknown

Describe the patient's medical condition and treatment.

Do not include any personally identifying information, such as names, for anyone other than this practitioner.

Your narrative description helps querying organizations understand more about the patient's medical condition and treatment.

4000 characters remaining

Describe the procedure(s) performed.

Do not include any personally identifying information, such as names, for anyone other than this practitioner.

Your narrative description helps querying organizations understand more about the procedures that were performed.

4000 characters remaining

Allegation(s) and Outcome

Allegation

What is the nature of the allegation?

Select one

Date of the event or incident

MM-DD-YYYY

Specific Allegation

Allegation - not otherwise classified (Specify)

Description

Description

+ Additional allegation

Outcome

Select one

Describe the allegations and injuries (or illnesses) that form the basis for the action or claim.

Do not include any personally identifying information, such as names, for anyone other than this practitioner.

Your narrative description helps querying organizations understand more about the allegations and injuries or illnesses that form the basis for the action or claim.

4000 characters remaining

Optional Reference Numbers

Entity Report Reference is an optional field that allows entities to add their own internal reference number to the report, such as a claim number. The reference number is available to all queriers.

Entity Report Reference

Customer Use is an optional field for you to create an identification for internal use. Your customer use number is only available to your organization.

Customer Use

Save and finish later | Continue to next step

3. Review

4. Certifier Information

Return to Options

Select an Allegation

Enter a keyword or phrase to find a specific allegation (Example: "failure")

Search

Failure to Take Appropriate Action

- Failure to use aseptic technique
- Failure to diagnose
- Failure to delay a case when indicated
- Failure to identify fetal distress
- Failure to treat fetal distress
- Failure to medicate
- Failure to monitor
- Failure to order appropriate medication
- Failure to order appropriate test
- Failure to perform preoperative evaluation

Don't see what you're looking for?

Medical Malpractice Payment Report: Initial Report

NATIONAL PRACTITIONER DATA BANK
NPDB

Public burden statement

1. Subject Information — Edit

2. Action Information — Edit

3. Review

Review your entries to be sure they are correct before you Continue.

Subject Information

Name:	**John Jones**
Gender:	**Male**
DOB:	**01-01-1960**
Home Address:	**555 Cabin Rd** **Chantilly, VA 20111**
Organization Name:	*None/NA*
Organization Type:	*None/NA*
Work Address:	*None/NA*
Profession/Field of Licensure:	**Physician (MD)**
Specialty:	**General Surgery**
License Info:	**111111 (VA)**
School/Institution, Year:	*None/NA*
SSN/ITIN:	**555555555**
NPI:	*None/NA*
DEA:	*None/NA*
FEIN:	*None/NA*
UPIN:	*None/NA*
Hospital Affiliation:	*None/NA*

Action Information

Payment Information

Total amount for this practitioner:	**$100,000.00**
Date of the payment:	**03-01-2017**
This payment represents:	**A single final payment**
Practitioners included in this payment:	**1**
This payment resulted from:	**A settlement**
Date of the settlement:	**02-27-2017**
The reporting organization is a(n):	**Insurance company - primary payer**
Other organizations that made payments for this practitioner:	**None**

Description of the settlement::	Lorem ipsum dolor sit amet, consectetur adispiscing alit. Aenean laoreet. Proin gravida dolor sit amet lacus accumsan et commodo.
Patient's Age:	**10 Days**
Gender:	**Male**
Type of Care:	**Inpatient**
Description of medical condition(s):	Lorem ipsum dolor sit amet, consectetur adispiscing alit. Aenean laoreet. Proin gravida dolor sit amet lacus accumsan et viverra justo sodales pulvinar tempor. Cum sociis natoque penatibus et magnis nascetur ridiculus mus. Nam fermentum, nulla luctus pharetra orci, sed rhoncus sapien nunc eget.
Description of prodcedures performed:	Lorem ipsum dolor sit amet, consectetur adispiscing alit. Aenean laoreet. Proin gravida dolor sit amet lacus accumsan et viverra justo sodales pulvinar tempor. Cum sociis natoque penatibus et magnis nascetur ridiculus mus. Nam fermentum, nulla luctus pharetra orci, sed rhoncus sapien nunc eget.
Nature of the allegation:	**Anesthesia Related**
Date of the event or incident:	**05-20-2017**
Patient's outcome:	**Major permanent injury**
Description of allegations or injuries (or illnesses) that form the basis for the action or claim:	Lorem ipsum dolor sit amet, consectetur adispiscing alit. Aenean laoreet. Proin gravida dolor sit amet lacus accumsan et viverra justo sodales pulvinar tempor. Cum sociis natoque penatibus et magnis nascetur ridiculus mus. Nam fermentum, nulla luctus pharetra orci, sed rhoncus sapien nunc eget.

Save and finish later | Continue to next step

4. Certifier Information

Return to Options

Medical Malpractice Payment Report: Initial Report

NATIONAL PRACTITIONER DATA BANK
NPDB

Public burden statement

1. Subject Information — Edit

2. Action Information — Edit

3. Review — Edit

4. Certifier Information

Send this report to a state board

Federal law (42 USC 11134(c)(1)) requires that you send a copy of your report to the appropriate state licensing board in the state in which the medical malpractice claim arose.

According to the NPDB records, licenses or certifications for **physicians** in the state of Maryland are administered by:
STATE MEDICAL EXAMINERS (Baltimore, MD)

To fulfill my organization's legal requirement to report this action to the state board:

- (●) I agree to allow the NPDB to send an electronic report notice to STATE MEDICAL EXAMINERS. I attest that this is the correct state board to notify based on where the medical malpractice claim arose.
- ( ) I attest that I will provide a copy of this report to the apppropriate state board.

Note:

- If you choose to send an electronic report notice to the state board you should receive an email as well as an NPDB correspondence within 7 days verifying that the state board has or has not viewed the electronic notice.
- If the appropriate state board is not listed here you must mail a printed copy of the official report (the Report Verification Document) to the appropriate state licensing board(s) to fulfill this requirement. If the practitioner was not licensed in the state in which the medical malpractice claim arose (which may be the case with payments for federally-employed practitioner(s) or if the claim arose for care provided at overseas military locations, you must send a copy of the report to the licensing board in at least one state in which the practitioner is licensed.

Certification

I certify that I am authorized to submit this transaction and that all information is true and correct to the best of my knowledge.

Your Name

TEST USER

Title

ADMIN

Phone

0005551111

Extension (optional)

Ext.

WARNING:
Any person who knowingly makes a false statement or misrepresentation to the National Practitioner Data Bank (NPDB) is subject to a fine and imprisonment under federal statute.

Submit to the NPDB

Return to Options

Non-visible Questions

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
Date of Death	Medical Malpractice Payment (1)	Below "Is this person deceased?"	Text Entry	The field is displayed if the user selects the "Yes" radio button for "Is this person deceased?"	
Organization Description	Medical Malpractice Payment (1)	Below Organization Type	Text Entry	The field is displayed if the user selects an organization type that requires a description.	
Name of Occupation	Medical Malpractice Payment (1)	Beside Profession or Field of Licensure	Text entry	The field is displayed if the user selects a profession or field of licensure that requires a description.	“Specialty” is displayed in place of “Name of Occupation” if the selected profession or field of licensure requires specialty information.
Specialty	Medical Malpractice Payment (1)	Beside Profession or Field of Licensure	Drop List	The field is displayed if the user selects a profession or field of licensure that requires information for specialty.	“Name of Occupation” is displayed in place of “Specialty” if the selected profession or field of licensure does not require information for a specialty.

FEIN (Federal Employer Identification Number)	Medical Malpractice Payment (1)	Below checkbox "Does the subject have an FEIN, or UPIN identification number?"	Text Entry	The field is displayed if the user selects the checkbox for "Does the subject have an FEIN, or UPIN identification number?"	Selecting the checkbox displays FEIN and UPIN text entry fields.
UPIN (Unique Physician Identification Numbers)	Medical Malpractice Payment (1)	Below FEIN text entry	Text Entry	The field is displayed if the user selects the checkbox for "Does the subject have an FEIN, or UPIN identification number?"	Selecting the checkbox displays FEIN and UPIN text entry fields.
Unknown	Medical Malpractice Payment (2)	Beside Total Amount Paid (to be Paid)	Checkbox	The field is displayed if the user selects “One of multiple payments” for “This payment represents.”	
Date of Judgment	Medical Malpractice Payment (2)	Below This payment was a result of:	Text Entry	The field is displayed if the user selects “Judgment” from the “This payment was a result of:” drop list.	If the user selects “Judgment” then the Date of Judgment, Adjudicative Body Name, Case Number, and Court File Number fields are displayed.
Adjudicative Body Name	Medical Malpractice Payment (2)	Below Date of the Judgment	Text Entry	The field is displayed if the user selects “Judgment” from the “This payment was a result of:” drop list.	If the user selects “Judgment” then the Date of Judgment, Adjudicative Body Name, Case Number, and Court File Number fields are displayed.

Case Number	Medical Malpractice Payment (2)	Beside Adjudicative Body Name	Text Entry	The field is displayed if the user selects “Judgment” from the “This payment was a result of:” drop list.	If the user selects “Judgment” then the Date of Judgment, Adjudicative Body Name, Case Number, and Court File Number fields are displayed.
Court File Number	Medical Malpractice Payment (2)	Below Adjudicative Body Name	Text Entry	The field is displayed if the user selects “Judgment” from the “This payment was a result of:” drop list.	If the user selects “Judgment” then the Date of Judgment, Adjudicative Body Name, Case Number, and Court File Number fields are displayed.
Date of Settlement	Medical Malpractice Payment (2)	Below This payment was a result of:	Text Entry	The field is displayed if the user selects “Settlement” from the “This payment was a result of:” drop list.	If the user selects “Settlement” then the Date of Settlement and “This is a global settlement for multiple claimants” checkbox fields are displayed.
This is a global settlement for multiple claimants	Medical Malpractice Payment (2)	Below Date of Settlement	Checkbox	The field is displayed if the user selects “Settlement” from the “This payment was a result of:” drop list.	If the user selects “Settlement” then the Date of Settlement and “This is a global settlement for multiple claimants” checkbox fields are displayed.

Total number of claimants included in this settlement	Medical Malpractice Payment (2)	Below “This is a global settlement for multiple claimants” checkbox	Text Entry	The field is displayed if the user selects “This is a global settlement for multiple claimants” checkbox.	
Total number of practitioners	Medical Malpractice Payment (2)	Below “Are other practitioners included in this case?”	Text Entry	The field is displayed if the user selects the “Yes” radio button for “Are other practitioners included in this case?”	If the user selects the “Yes” radio button for “Are other practitioners included in this case?” then “Total number of practitioners” and “Total amount paid (or to be paid) for all practitioners in this case fields” are displayed.
Total amount paid (or to be paid) for all practitioners in this case	Medical Malpractice Payment (2)	Below “Total number of practitioners”	Text Entry	The field is displayed if the user selects the “Yes” radio button for “Are other practitioners included in this case?”	If the user selects the “Yes” radio button for “Are other practitioners included in this case?” then “Total number of practitioners” and “Total amount paid (or to be paid) for all practitioners in this case fields” are displayed.

Has a state guaranty fund or state excess judgement fund made a payment for this practitioner in this case (or is such payment expected to be made)?	Medical Malpractice Payment (2)	Below “Your organization’s relationship with this practitioner”	Text Entry	The field is displayed if the user selects an applicable option for “Your organization’s relationship with this practitioner”	
Total amount paid (to be paid)	Medical Malpractice Payment (2)	Below radio button for “Has a state guaranty fund or state excess judgement fund made a payment for this practitioner in this case (or is such payment expected to be made)?”	Text Entry	The field is displayed if the user selects the “Yes” radio button for “Has a state guaranty fund or state excess judgement fund made a payment for this practitioner in this case (or is such payment expected to be made)?”	
Has a self-insured organization and/or other insurance company/companies made payments for this practitioner in this case (or is such payment expected to be made)?	Medical Malpractice Payment (2)	Below “Your organization’s relationship with this practitioner”	Text Entry	The field is displayed if the user selects an applicable option for “Your organization’s relationship with this practitioner”	
Total amount paid (to be paid)	Medical Malpractice Payment (2)	Below radio button for “Has a self-insured organization and/or other insurance company/companies made payments for this practitioner in this case (or is such payment expected to be made)?”	Text Entry	The field is displayed if the user selects the “Yes” radio button for “Has a self-insured organization and/or other insurance company/companies made payments for this practitioner in this case (or is such payment expected to be made)?”	

Description	Medical Malpractice Payment (2)	Below “Specific Allegation”	Text Entry	The field is displayed if the user selects an allegation that requires a description.	

State Changes

Label	PDF Name	Item Type	Trigger
Public Burden Statement	Medical Malpractice Payment	Modal	When the user selects the Public Burden Statement link the modal is displayed.
Select a Profession or Field of Licensure	Medical Malpractice Payment	Modal	When the user sets focus on the Profession or Field of Licensure text entry, the modal to select a profession is displayed and focus is set on the Search text entry. The user can enter text in the Search text box to find a specific profession or select a profession from the list without searching. The modal is hidden once the user selects a profession from the list. The user's selection populates the Profession or Field of Licensure text entry.
Name of Occupation	Medical Malpractice Payment	Text Entry	Text entry is disabled if the user does not select a profession or field of licensure requiring a description.
License Number	Medical Malpractice Payment	Text Entry	Text entry is disabled if the user selects the "No/ Not sure" option for "Does the subject have a license for the selected profession or field of licensure?"
Select an Allegation	Medical Malpractice Payment	Modal	When the user sets focus on the Specific Allegation text entry, the modal to select an act is displayed and focus is set on the Search text entry. The user can enter text in the Search text box to find a specific act or select an act from the list without searching. The modal is hidden once the user selects an act from the list. The user's selection populates the Specific Allegation text entry.