DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service
Indian Health Service
«FacilityName»
«FacilityAddress»

VERIFICATION OF MEDICAL MALPRACTICE

August 2, 2023

«RS_Name»
«RS_Address» «RS_Address2»
«RS_City», «RS_State» «RS_Zip»

Email: «RS_Email»

To Whom It May Concern:

RE: «FormalNameWithDegree» **DOB: «BirthDate»** **SSN: «SSN»**

The practitioner listed above has applied to our facility for appointment/reappointment. On «hisher» application this practitioner has indicated a professional liability policy with your company.

Before we can process this application further, we require verification of dates of medical malpractice coverage and a claims history:

Current/Previous Policy #:	**«IS_PolicyNumber»**
Inception Date:	**«IS_Issued»**
Expiration Date:	**«IS_Expired»**
Provider's first date of coverage:	**_____**
Policy Limits:	**«IS_Coverage»**
Any claims?	***YES____ NO____** *If **YES**, please attach a copy/copies of claim history.

Signature: _____ Date: _____

Printed Name and Title: _____

Please return this form or other response via secure email or fax to _____.

Sincerely,

«UserFullName»
Medical Staff Professional
_____ Indian Medical Center

Attachment: Statement of Understanding and Release «Image:File_REL»