

Entity: TEST AGENCY (TEST,ST) | User: Testuser [Sign Out](#)

NATIONAL PRACTITIONER DATA BANK
NPDB

MEDICAL MALPRACTICE PAYMENT: INITIAL REPORT

[Privacy Policy](#) | OMB Number: 0915-0126 Expiration Date: mm/dd/yyyy

Public Burden Statement ✕

OMB Number: 0915-0126 Expiration Date: XX/XX/20XX

Public Burden Statement: The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state-to-state without disclosure or discovery of previous damaging performance. The statutes and regulations that govern and maintain NPDB operations include: [Title IV of Public Law 99-660, Health Care Quality Improvement Act \(HCQIA\) of 1986](#), [Section 1921 of the Social Security Act](#), [Section 1128E of the Social Security Act](#), and [Section 6403 of the Patient Protection and Affordable Care Act of 2010](#). The NPDB regulations implementing these laws are codified at [45 CFR Part 60](#). 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 information collection is 0915-0126 and it is valid until XX/XX/202X. This information collection is mandatory ([45 CFR Part 60](#)). [45 CFR Section 60.20](#) provides information on the confidentiality of the NPDB. Information reported to the NPDB is considered confidential and shall not be disclosed outside of HHS, except as specified in [Sections 60.17, 60.18, and 60.21](#). Public reporting burden for this collection of information is estimated to average .75 hours per response, 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 14N136B, Rockville, Maryland, 20857 or paperwork@hrsa.gov.

[Close](#)

1. Subject

Please when

Person

Last Name
SMITH
[+ Add](#)

Gender
 Male

Birthdate
MM / D

Is this
 No

Date of
MM /

Practitioner's Address

Type of Address

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1. Subject Information

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

Need Help ?

Personal Information

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

SMITH

[+ 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

Practitioner's Address

Type of Address

If the home address is not known, enter a work address.

Home Work

Home Address/Address of Record

Country

United States

Address [Entering a military address?](#)

Address Line 2

City

State

CHOOSE ONE FROM LIST

ZIP

[+ Add a Work Address](#)

Profession and Licensure

Against which license or certification was the action taken?

Profession or Field of Licensure

Description (Optional)

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

Yes No/Not sure

State

CHOOSE ONE FROM LIST

License Number

Add any other health care licenses the individual holds

[+ 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).

[What if the practitioner has not graduated?](#)

Name of School or Institution

Completion Year

YYYY

[+ Additional school or institution](#)

Identification Numbers

SSN (Social Security Number)

[+ Additional SSN](#)

NPI (National Provider Identifier)

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

[+ Additional NPI](#)

DEA (Drug Enforcement Administration) Number

[+ Additional DEA](#)

Hospital Affiliation

Hospital Name

City

State

CHOOSE ONE FROM LIST

[+ Additional hospital](#)

Add this subject to my subject database

[What is a subject database?](#)

Save and finish later

Continue

2. Action Information

3. Review

4. Certifier Information

Return to Options



What type of license are you reporting?

Search

Recently Used

Occupational Therapist ✖

Behavioral Health Occupations

Other Behavioral Health Occupation - Not Classified, Specify - BEHAVIOR ANALYST

Psychologist/Psychological Assistant

Psychologist

Psychologist - CERTIFIED

Rehabilitative, Respiratory and Restorative Service Practitioner

Occupational Therapist

Occupational Therapy Assistant

Physical Therapist

Physical Therapy Assistant

Health Care Facility Administrator

Health Care Facility Administrator

[Report a different license](#)

1. Subject Information Edit

2. Action Information

Payment for This Practitioner

Amount of this payment

\$

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)

\$

This payment was a result of

Settlement

Date of the Settlement

MM / DD / YYYY

Adjudicative Body Name

Case Number

Court File Number

Describe the settlement including any conditions or terms of payment.

Do not include any personally identifiable information, such as names, for anyone except the subject of this report.

Your [narrative description](#) helps querying organizations understand more about the payment and why it was made.

4000 characters remaining

Spell Check

This is a global settlement for multiple claimants.

Total number of claimants included in the settlement

Payments 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

\$

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 a payment expected to be made)?

Yes No Unknown

Total amount paid (or to be paid)

\$

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)

\$

Acts or Omissions

Primary Claimant's Age at Time of Initial Event:

Days Unknown

Primary Claimant's Gender:

Male Female Unknown

Type of Care

Inpatient Outpatient Both Unknown

Describe the primary claimant's medical condition and treatment.

Do not include any personally identifiable information, such as names, for anyone except the subject of this report.

Your [narrative description](#) helps querying organizations understand more about the patient's medical condition and treatment.

4000 characters remaining

Spell Check

Describe the procedure(s) performed.

Do not include any personally identifiable information, such as names, for anyone except the subject of this report.

Your [narrative description](#) helps querying organizations understand more about the procedures that were performed.

4000 characters remaining

Spell Check

Allegation(s) and Outcome

What is the nature of the allegation?

CHOOSE ONE FROM LIST

Allegation
Date of the event or incident
MM / DD / YYYY <input type="text"/>
Specific Allegation
Allegation - Not Otherwise Classified, Specify <input type="text"/>
Description
<input type="text"/>

+ [Additional allegation](#)

Outcome

CHOOSE ONE FROM LIST

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

Do not include any personally identifiable information, such as names, for anyone except the subject of this report.

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

Spell Check

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

3. Review

4. Certifier Information

Return to Options

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1. Subject Information

Edit

2. Action Information

Edit

3. Review

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

Subject Information [Edit](#)

Subject Name: SMITH, JOHN
 Other Name(s) Used: None/NA
 Gender: UNKNOWN
 Date of Birth: 01/01/1960
 Organization Name: None/NA
 Work Address: None/NA
 City, State, ZIP: None/NA
 Home Address: 5 560TH ST
 City, State, ZIP: MARCUS, IA 11111
 Deceased: UNKNOWN
 Social Security Numbers (SSN): ***-**-6666
 National Provider Identifiers (NPI): None/NA
 Professional School(s) & Year(s) of Graduation: UNIVERSITY (2000)
 Occupation/Field of Licensure: REGISTERED NURSE
 State License Number, State of Licensure: 11111, KY
 Drug Enforcement Administration (DEA) Numbers: None/NA
 Hospital Affiliation(s): None/NA
 None/NA

Action Information [Edit](#)

Relationship of Entity to This Practitioner: SELF-INSURED ORGANIZATION

Payments By This Payer For This Practitioner

Amount of This Payment for This Practitioner: \$ 1.00
 Date of This Payment: 02/02/2020
 This Payment Represents: A SINGLE FINAL PAYMENT
 Total Amount Paid or to Be Paid by This Payer for This Practitioner: \$ 1.00
 Payment Result of: SETTLEMENT
 Date of Judgment or Settlement, if Any: 02/02/2020
 Adjudicative Body Case Number: None/NA
 Adjudicative Body Name: TEST COURT
 Court File Number: None/NA
 Description of Judgment or Settlement and Any Conditions, Including Terms of Payment: Test narrative

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: \$ 1.00
 Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case: 1

Payments By Others For This Practitioner

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
 Amount Paid or Expected to Be Paid by the State Fund: \$ 1.00
 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?: None/NA
 Amount Paid or Expected to Be Paid by Self-Insured Organization(s) and/or Other Insurance Company/Companies: None/NA

Classification Of Act(s) Or Omission(s)

Patient's Age at Time of Initial Event: 1 DAYS
 Patient's Gender: UNKNOWN
 Patient's Type: UNKNOWN
 Description of the Medical Condition With Which the Patient Presented for Treatment: Test narrative
 Description of the Procedure Performed: Test narrative
 Nature of Allegation: OTHER MISCELLANEOUS (090)
 Specific Allegation: FAILURE TO DIAGNOSE (101)
 Date of Event Associated With Allegation or Incident: 02/01/2020
 Outcome: EMOTIONAL INJURY ONLY (01)
 Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based: Test narrative

Save and finish later

Continue

4. Certifier Information

Return to Options

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1. Subject Information

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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 **Registered Nurse** in the state of STATE NAME are administered by:

STATE BOARD OF NURSING (CITY, ST)

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 BOARD OF NURSING. 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 appropriate state board.

Note:

- If you choose to send an electronic report notice to the state board, you should receive an email as well as a Data Bank 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 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 practitioners) 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.

Authorized Submitter's Name

TEST

Authorized Submitter's Title

TEST

Authorized Submitter's Phone

7777777777

Ext.**WARNING:**

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

[Save and finish later](#)[Submit](#)[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.	
Specialty	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.
Description	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.	"Description" 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.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
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.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
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.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
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.

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
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)?"	

Label	PDF Name (step)	Location	Response Input Item	Visibility Trigger	Other
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
OMB Number: 0915-0126 Expiration Date: mm/dd/yyyy	Medical Malpractice Payment	Modal	When the user selects the link the modal is displayed with the public burden statement content.
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.