



MISSOURI MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION

NOTICE OF PHYSICIAN CLAIM, POTENTIAL CLAIM OR LAWSUIT

PLEASE NOTE: DO NOT MAKE ANY ALTERATIONS OR ADDITIONS IN YOUR MEDICAL RECORDS. KEEP YOUR MEDICAL RECORD CONFIDENTIAL AND PROPERLY SECURED.

INSURED NAME: _____ **SS #:** _____

OFFICE ADDRESS: _____ **PHONE:** _____

CONTACT PERSON: _____ **PHONE:** _____

PATIENT NAME: _____ **D/BIRTH** _____

ADDRESS: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** _____ **MARITAL STATUS** _____ **DEPENDENTS** _____

DATE OF INCIDENT _____ **DATE OF YOUR FIRST NOTICE** _____

LOCATION: OFFICE (address) _____

HOSPITAL (name) _____

METHOD OF NOTICE: ____ADVERSE EVENT ____PATIENT COMPLAINT ____RECORD REQUEST

____ATTORNEY LETTER ____LAWSUIT/DATE SERVED _____

STILL TREATING PATIENT? ____YES/NO **NOTICE TO OTHER CARRIER?** ____YES/NO

SUMMARY OF MEDICAL TREATMENT (OBJECTIVE FACTS ONLY):

ENCLOSE THE FOLLOWING DOCUMENTS WITH THIS NOTICE AND SEND TO THE ADDRESS NOTED BELOW: 1) PERTINENT MEDICAL RECORDS; 2) ALL RELATED CORRESPONDENCE; 3) **NOTICE OF INTENT**, IF APPLICABLE; 4) **SUMMONS AND COMPLAINT**, IF APPLICABLE.

MMMJUA CLAIMS

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