DOCTORS & SURGEONS
NATIONAL RISK RETENTION GROUP
Specializing in Medical Liability Services & Products

Claim Advisory Report

INSURED INFORMATION:

Named Insured: ______________________

Involved Insured(s) and/or Additional Insured(s) ***(please include contact information)*** ______________________

CLAIMANT INFORMATION:

Claimant Name: ______________________

Claimant Address: ______________________

Date of Birth: ______________________

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security Number: ______________________

Date of Incident: ______________________

Location of Incident: ______________________

STATUS OF CLAIM:

Date Received By Insured: *(This **must** be filled in with the date your department first knew about this claim)*

- ☐ Unasserted potentially compensable event ______________________
- ☐ Medical record request by non-attorney ______________________
- ☐ Medical record request by attorney ______________________
- ☐ Letter of Intent or verbal request for compensation ______________________
- ☐ Lawsuit ______________________
  - Date of service on insured: ______________________
  - Date filed with the Court: ______________________

Please attach all correspondence, legal papers served upon an insured, and substantive medical records as well as the policy for the insured and all endorsements to the policy.

DESCRIPTION OF INCIDENT: (*Include location, what happened and the result)*

Recommended Counsel: ______________________

Submitted By: ______________________

Email Address and Telephone Number: ______________________

Date Submitted: ______________________

Submit form and attachments by email to:

Western Litigation, Inc.
Dina Larsen
(303) 889-2536
claims@dsnrrg.com