UMIA
Coverage without compromise

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Name of insured _____ Policy number _____

Involved health care provider _____

Phone number for involved provider _____

Mailing address for involved provider _____

Confidential email address for involved provider _____

Name of patient or claimant _____ Patient's DOB _____

Is patient a Medicare beneficiary? ☐ Yes ☐ No ☐ Unknown

HICN _____

Is patient a Medicaid beneficiary? ☐ Yes ☐ No ☐ Unknown

SID# _____

Patient's address _____ Patient's phone number _____

Date of event _____ Date notified of event _____

REPORT TYPE

☐ Notice only - potential claim (PCE)

☐ Claim (demand for compensation)

☐ Lawsuit Date served _____

☐ Medical liability screening panel

☐ Request for mediation

☐ Deposition or meeting request

☐ Request for medical records

☐ Licensing board issue

☐ Other _____

ACTION REQUESTED

☐ No action required

☐ Claim investigation

☐ Legal assistance

☐ Call to discuss

Contact person _____

Contact No. _____

Email address _____

☐ Patient safety consult

Description of incident

Was this incident reported to a prior carrier? ☐ Yes ☐ No

Please submit this to claims@UMIA.com. If you requested a phone call, you will receive a call within 2 business days. Thank you.