# CONFIDENTIAL

**Please Email OR Fax Form To:**
**Email: hpreports@cna.com**
**Fax: 800-446-8632**
**Phone: 800-341-3684**

## CNA HEALTHCARE INCIDENT/CLAIM REPORTING FORM

Today's Date_____

Has this matter previously been reported to CNA?_____ If so, claim number? _____

Is this a (please check one):

- ❒ Notice of an Adverse Healthcare Incident (from the Oregon Patient Safety Commission)
- ❒ Notice of Incident
- ❒ Notice of claim other than lawsuit
- ❒ Notice of Lawsuit-When Served:_____
- ❒ Professional board complaint or inquiry
- ❒ Deposition request
- ❒ Request for records
- ❒ Other – Explain: _____

Date you received notice of the matter referenced above:_____

**Please attach copies of all pertinent healthcare records and all correspondence received from or sent to the patient or his/her representative regarding the matter that you are reporting.**

**INSURED INFORMATION**

| | |
|---|---|
| Named Insured on the Policy: | Policy Number: |
| Medical Practitioner Name: | Specialty: |

| | |
|---|---|
| Practice Office Address:<br><br>**Primary Contact, Email, Office and Cell Phone Numbers**: | Practice Mailing Address (if different from practice address): |
| Practitioner's Email Address: | Office Phone and Fax Number: |

**CLAIM / INCIDENT INFORMATION**

| | | |
|---|---|---|
| Patient Name: Date of Birth: | Date of Injury: Last Treatment Date: | Patient Gender:<br>❒ Male ❒ Female |

Provide a brief narrative of the care and treatment rendered surrounding the allegation(s) made against you or the circumstances of the incident you are reporting. **Please do not offer your opinion.** Attach an additional page if necessary.

Completed By:_____ Title:_____ Phone Number:_____

Form revised 2018-05-01