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: **Primary Contact, Office and Cell Phone Numbers**:	Practice Mailing Address (if different from practice address):
E-MAIL Address:	Office Fax Number:

CLAIM / INCIDENT INFORMATION

Patient Name and Date of Birth:	Date of Injury and Last Treatment Date:	Patient Gender: ❒ 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:_____