Professional Liability Claim Form

- **This form must be completed in its entirety before your application will be considered for approval.**
- Please submit one form per unique claim.
- If additional space is needed, attach additional pages.
- Claim – any notice of intent, claim, or suit, whether settled or pending, regardless of result, arising from your professional activity and brought against you within the last five (5) years.
- Claim time line – any activity within the last five (5) years related to the below listed claim.
- Each incident/claim form must have a provider's original signature/date.
- Provide official / court documentation of claim dismissed, and/or settled.
- Provide official documentation (from the Attorney) for claims abandoned/dropped.

Patient Name (or initials)	Age	Sex	Date(s) of Consultation
Presenting Condition/Dx			
Please provide a narrative description of the role that you played in this patient's care including a timeline of this care. *Narrative must provide adequate clinical detail for evaluation purposes*.			
Date of Incident	Location of Incident		
Allegation Against You			
Patient Outcome			
Was this claim reported to your insurance carrier? *If Yes, list name of carrier and policy number.*	Name and address of other physicians and hospitals, if any, involved in the claim or suit.		

Indicate present status or disposition of claim, including amount of settlement or judgment.

___ Incident Only
___ Suit threatened, no action taken
___ Dropped by claimant on ___/___/___
___ Awaiting court action
___ Awaiting settlement
___ Unknown
___ Court trial with defense verdict, final date ___/___/___
___ Out of court settlement on ___/___/___. Total amount paid $ ________________
Total amount paid on your behalf $ ___________
___ Amount of Court Award $ _________________
___ Summary judgment in my favor, dismissed on ___/___/___

_________________________ **Signature of Applicant**

_________________________ **Print Name of Applicant**

_______________ **Date**

Please send completed form and attachments by email or fax to the following:

Attn: **CMS Provider Management**
Email: cmsproviderhelp@floridahealth.gov
Fax: (850) 487-1279