



Medical Malpractice Joint Underwriting Association of Rhode Island

Notice of Healthcare Professional Claim, Potential Claim or Lawsuit

Please Note: Do Not Make Any Alterations or Additions in Your Medical Records. Keep Your Medical Record Confidential and Properly Secured.

Insured Name: _____

Policy Number: _____

Contact/Title: _____ **Phone:** _____

Patient Name: _____

Date of Incident: _____ **Date of First Notice:** _____

Location: _____

Method Of Notice:

_____ Adverse Event _____ Patient Complaint _____ Record Request _____ For Deposition

_____ Attorney Letter _____ Lawsuit/Date Served _____ Department of Health

Still Treating Patient? _____ Yes/No Notice to Other Carrier? _____ Yes/No

Summary of Medical Treatment (Objective Facts Only):

To Report an Incident or File a Claim, Please Fax or Email This Form To:

Fax (Attention: Claims Manager): 401-369-8241

Email (Attention: Claims Manager): Donna_Cacicia@gbtpa.com

Please Enclose the Following Documents with This Notice and Send to The Address Below:

1. Pertinent Medical Records
2. All Related Correspondence
3. Notice of Intent (If Applicable)
4. Summons and Complaint (If Applicable)

MMJUA of RI
Attn: Claims Department
One Turks Head Place, Suite 200
Providence, RI 02911

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.