

**MISSOURI MEDICAL MALPRACTICE JOINT UNDERWRITING ASSOCIATION**

**NOTICE OF PHYSICIAN 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:** \_\_\_\_\_ **SS #:** \_\_\_\_\_

**OFFICE ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**CONTACT PERSON:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **D/BIRTH** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **MARITAL STATUS** \_\_\_\_\_ **DEPENDENTS** \_\_\_\_\_

**DATE OF INCIDENT** \_\_\_\_\_ **DATE OF YOUR FIRST NOTICE** \_\_\_\_\_

**LOCATION:** OFFICE (address) \_\_\_\_\_

HOSPITAL (name) \_\_\_\_\_

**METHOD OF NOTICE:** \_\_\_ADVERSE EVENT \_\_\_PATIENT COMPLAINT \_\_\_RECORD REQUEST

\_\_\_\_ATTORNEY LETTER \_\_\_\_\_LAWSUIT/DATE SERVED \_\_\_\_\_

**STILL TREATING PATIENT?** \_\_\_\_\_YES/NO **NOTICE TO OTHER CARRIER?** \_\_\_\_\_YES/NO

**SUMMARY OF MEDICAL TREATMENT (OBJECTIVE FACTS ONLY):**

ENCLOSE THE FOLLOWING DOCUMENTS WITH THIS NOTICE AND SEND TO THE ADDRESS NOTED BELOW: 1) PERTINENT MEDICAL RECORDS; 2) ALL RELATED CORRESPONDENCE; 3) **NOTICE OF INTENT**, IF APPLICABLE; 4) **SUMMONS AND COMPLAINT**, IF APPLICABLE.

**MMMJUA CLAIMS**

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