



## Claim/Incident Reporting Form

Policy Number: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Group's Name (if applicable): \_\_\_\_\_

Office Address \_\_\_\_\_ City, State, Zip

Mailing Address \_\_\_\_\_ City, State, Zip

Office Telephone Number \_\_\_\_\_

Date/Time of Incident: \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Name of person/entity making the claim: \_\_\_\_\_

Contact Information for person/entity making the claim:

Street Address (if known) \_\_\_\_\_ City, State, Zip

Telephone Number (if known) \_\_\_\_\_

Brief narrative description of allegation against you (please do not offer your opinion at this point):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

➤ Please attach any lawsuit papers or legal proceedings, as well as any other pertinent documents or correspondence.

**Please mail or fax form to:**

Physicians Protector Plan

P.O. Box 1309

Tampa, FL 33601-1309

Fax: (813) 222-4120 ◆ Phone : (813)222-4200