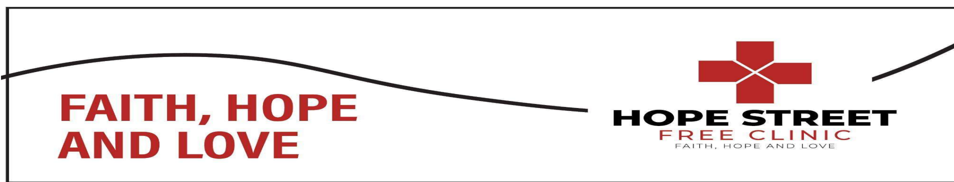



# Health Center Claims Notification Form

## Section 1: Incident Information

- **Date of Incident:** ______________________________
- **Time of Incident:** ______________________________
- **Location of Incident:**
  - ☐ Exam Room ☐ Waiting Area ☐ Restroom
  - ☐ Hallway ☐ Other: ____________________________
- **Type of Incident:**
  - ☐ Patient Injury ☐ Staff Injury ☐ Property Damage
  - ☐ Medication Error ☐ Security Incident
  - ☐ Other: ____________________________

## Section 2: Reporting Individual Information

- **Name of Reporter:** ______________________________
- **Job Title/Role:** __________________________________
- **Contact Information:**
  - Phone: ________________________ Email: _________________________

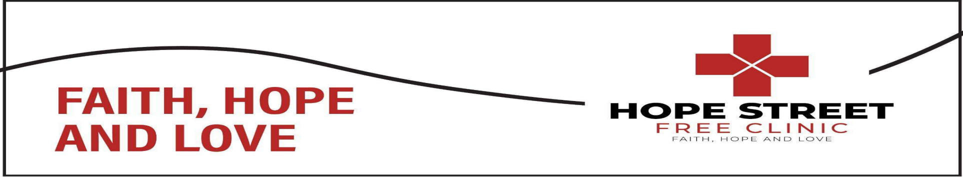
## Section 3: Involved Individuals

### Patient Information

- **Patient Name:** __________________________________
- **Date of Birth:** __________________________________
- **Medical Record Number:** _________________________
  - Phone: ________________________
  - Address: _________________________

### Staff Information

- **Staff Name:** ____________________________________
- **Job Title/Role:** __________________________________
- **Contact Information:**
  - Phone: ________________________ Email: _________________________




## Section 4: Description of Incident and Claim

- **Detailed Description of Incident:**

  ______________________________________________________________
  ______________________________________________________________
  ______________________________________________________________

- **Nature of Claim:**
  - ☐ Personal Injury
  - ☐ Property Damage
  - ☐ Wrongful Death
  - ☐ Other: ________________________
- **Claim Amount (if known):** ______________________

## Section 5: Documentation Attached

- **Attach Relevant Documents:**
  - ☐ Incident Report
  - ☐ Court Filings
  - ☐ Demand Letters
  - ☐ Communications from Patient/Attorney
  - ☐ Medical Records
  - ☐ Photographs
  - ☐ Witness Statements
  - ☐ Other: ________________________

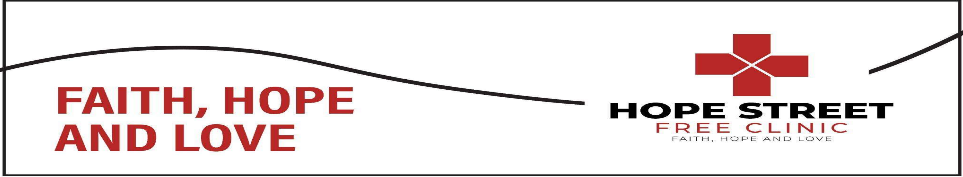
## Section 6: Immediate Actions Taken

- **Actions Taken Immediately Following the Incident:**

  ______________________________________________________________
  ______________________________________________________________
  ______________________________________________________________

## Section 7: Notification to HHS Office of General Counsel

- **Date Sent to HHS OGC:** ________________________




- **Method of Sending:**
  - ☐ Email
  - ☐ Mail
  - ☐ Fax
  - ☐ Other: ________________________
- **Contact Person at HHS OGC:** ____________________
- **Contact Information:**
  - Phone: _______________________
  - Email: ________________________

## Section 8: Follow-Up Actions

- **Follow-Up Actions Taken:**

---

---

---

- **Additional Actions Needed:**

---

---

## Section 9: Signature

- **Reporter's Signature:** ____________________________
- **Date:** ___________________________________________

---

**Instructions:**

- Complete this form as soon as possible after receiving notice of a claim or potential claim.
- Attach all relevant documentation and evidence.
- Submit the form to the Claims Coordinator or designated person.
- Ensure that the notification is sent to the HHS Office of General Counsel promptly.
- Retain a copy for your records.