COMMONWEALTH OF KENTUCKY
Department of Insurance
P .O. Box 517
Frankfort, Kentucky 40602-0517

PROPERTY AND CASUALTY DIVISION

MEDICAL MALPRACTICE CLAIM FORM

Name and Address of Insurer: _____

Name of Health Care Provider: _____

Health Care Provider's Address: _____

Name of Claimant: _____

Address of Claimant: _____

Nature of the Claim: _____

Damages Asserted and the Alleged Injury: _____

Amount of any Settlement or Judgment: _____

Date of Settlement or Judgment: _____

_____
Company Representative

_____
Telephone Number

KRS 304.40-310 requires all malpractice claims settled or adjudicated to final judgment against a health care provider be reported to the Department by the medical malpractice insurer or the self-insured health care provider within sixty (60) days following final settlement or disposition of the claim.