Send completed form and attachments by fax or email to the following:

CMS Provider Management
Fax: (850) 487-1279
Email: cmsproviderhelp@doh.state.fl.us

Professional Liability Claim Form

- **This form must be completed in its entirety before your application will be considered for approval.**
- If additional space is needed, attach additional pages.
- Claim – any notice of intent, claim, or suit, whether settled or pending, regardless of result, arising from your professional activity and brought against you within the last five (5) years.
- Claim time line – any claim activity within the last five (5) years.
- A photocopy of this authorization shall be considered as effective and as valid as the original.
- Each incident/claim form must have a provider's original signature/date within 60 days of application submission.
- Provide official / court documentation of claim dismissed, and/or settled.
- Provide official documentation (from the Attorney) for claims abandoned/dropped.

Patient Name (or initials)	Age	Sex	Date of Consultation

Condition/Dx

Describe care & treatment of patient. *Narrative must provide adequate clinical detail for evaluation purposes.*

Date of Incident	Location of Incident

Allegation Against You

Patient Outcome

Was this claim reported to your insurance carrier? *If Yes, list name of carrier and policy number.*

☐ Yes
☐ No

Name and address of other physicians and hospitals, if any, involved in the claim or suit.

Indicate present status or disposition of claim, including amount of settlement or judgment.

___ Incident Only
___ Suit threatened, no action taken
___ Dropped by claimant on ___/___/___
___ Awaiting court action
___ Awaiting settlement
___ Unknown
___ Court trial with defense verdict, final date ___/___/___
___ Out of court settlement on ___/___/___. Total amount paid $ _____
Total amount paid on your behalf $ _____
___ Amount of Court Award $ _____
___ Summary judgment in my favor, dismissed on ___/___/___

_____ _____ _____
Signature of Applicant **Print Name of Applicant** **Date**