



NEW HAMPSHIRE INSURANCE DEPARTMENT
MEDICAL PROFESSIONAL LIABILITY INSURANCE EARLY OFFER REQUEST REPORT

MAIL TO: NHID - ACTUARY
 21 SOUTH FRUIT ST, SUITE 14
 CONCORD NH 03301

Date Report Prepared:

SEE INSTRUCTIONS ON REVERSE		PLEASE TYPE OR PRINT
1a NAME OF INSURER		1b ADDRESS OF INSURER
1c NAIC GROUP & COMPANY CODE		
1d CONTACT PERSON RESPONSIBLE FOR THE REPORT		
Name	Title	Tel. No. E-Mail

CLAIM FILE IDENTIFICATION

2a Claim Number	2b Date of Injury	2c Date Reported	2d Date Reopened	2e Original Claim Number
2f Place of Occurrence Code	2g Place of Occurrence Address			2h Total Number of Defendants in Claim

INSURED/PROVIDER

3a Name	3b License Number	3c Date of Birth
3d Address (Street, P.O. Box, City/Town, State, Zip Code)		
3e Profession Code of Insured	3f Specialty Code of Insured	3g Practice Code of Insured

INSTITUTION (IF INJURY OCCURRED IN INSTITUTION)

4a Name:	4b Address:	4c Location of Injury Code:
----------	-------------	-----------------------------

INJURED PERSON

5a Name	5b Date of Birth	5c Sex
5d Address		
6a Plaintiff Attorney's Name	6b Plaintiff Attorney's Firm	6c Address

CLAIM INFORMATION AND FINANCIAL DATA

7a Nature and Substance of Claim	7b Severity of Injury Code
7c Act or Omission Codes (Enter three Digit Code in Appropriate Category)	
Diagnosis <input type="text"/>	Anesthesia <input type="text"/>
Surgery <input type="text"/>	Medication <input type="text"/>
Intravenous & Blood Products <input type="text"/>	Obstetrics <input type="text"/>
Treatment <input type="text"/>	Monitoring <input type="text"/>
Biomedical Equipment/Product Medication <input type="text"/>	Miscellaneous <input type="text"/>

8a Date Early Offer Requested	8b Date Early Offer Made	8c Date Early Offer Declined
8d Early Offer Amount of Request	8e Early Offer Amount Offered	8f Early Offer Amount Paid

9a Reserve Amount for Indemnity	9b Reserve Amount for Expense
9c Date of Payment or Closure	9d Indemnity paid by you on behalf of this defendant (OTHER THAN EARLY OFFER)
9e Loss adjustment expense paid to defense counsel	9f All other allocated loss adjustment expense paid

Submit an initial report when a request for an Early Offer is received.

All claims closed without payment and claims with payment must be reported. Report all dollar amounts in whole \$\$\$, all dates as MM/DD/YY. Reports are to be submitted to the Insurance Department annually after the initial report until the claim is settled and closed, regardless of whether the Early Offer is accepted or declined. When a claim is closed, the total form must be completed. Attach an explanation for any items left blank.

- 1a. **Name of Insurer:** Enter name of company or self-insurer reporting this claim.
- 1b. **Address of Insurer:** Enter address of company or self-insurer reporting this claim
- 1c. **NAIC Group & Company Code:** For insurance companies use NAIC group-company code; self-insurers contact Insurance Department for assigned number.
- 1d. **Contact Person Responsible for the Report.** Enter contact's name, title, tel. #, e-mail address.
- 2a. **Claim Number:** Assign a distinguishing claim file identification number to each claim report. This number must be sufficient identification to enable tracking of a particular claim.
- 2b. **Date of Injury:** Date principal or alleged injury occurred.
- 2c. **Date Reported:** Date when claim was first reported to insurer or self-insurer.
- 2d. **Date Reopened:** Date claim was reopened.
- 2e. **Original Claim Number (If Claim is Reopened):** If claim is reopened, original claim number used when claim was originally filed with the Department.
- 2f. **Place of Occurrence Code:** Enter the appropriate code for the place where the principal injury occurred:

(1) Hospital Inpatient Facility	(6) Patient's Home
(2) Emergency Room	(7) Other Outpatient Facility (including clinics)
(3) Hospital Outpatient Facility	(8) Other (describe place)
(4) Nursing Home	
(5) Physician's Office	

If the claim resulted from a diagnostic error, code place where error occurred, regardless of where it was discovered or treated.
- 2g. **Place of Occurrence Address:** Enter the address where the injury occurred.
- 2h. **Total Number of Defendants in Claim:** Enter total number of defendants (persons and institutions other than John Does) involved in claim.
- 3a. **Insured/Provider Name:** Enter name of insured or the provider of whom the Early Offer request was made.
- 3b. **License Number:** Enter New Hampshire license number of insured health care professional. If unavailable, enter federal identification number; not applicable to clinics and corporations.
- 3c. **Date of Birth:** Enter insured's date of birth. Enter 'N/A' if an institution, group or partnership.
- 3d. **Address:** Enter complete address of insured.
- 3e. **Profession Code of Insured:** Enter appropriate code for insured named in 3a.

(01) Physician and/or Surgeon	(06) Pharmacy
(02) Hospital	(07) Optometrist
(03) Nurse	(08) Chiropractor
(04) Nursing Home	(09) Podiatrist / Chiropodist
(05) Dentist	(99) Clinic / Corporation / Other
- 3f. **Specialty Code of Insured:** Enter appropriate 5-digit specialty code. Licensed insurers - use IAO Common Statistical Base Classification Code used for underwriting. Self-insurers - contact Insurance Department for list of codes.
- 3g. **Practice Code of Insured:** Enter one of the following codes if the insured is a physician or other medical professional. Not applicable if hospital or health care facility is the insured.

(01) Institutional (including academic)	(06) Intern or Resident
(02) Professional Corporation or Partnership (Group)	(99) All Other Employees
(03) Self-employed	
(04) Employed Physician	
(05) Employed Nurse	
- 4a. **Name of Institution:** Enter name of institution, if injury occurred in an institution (2f. should be coded 1, 2, 3, 4, 7, or 8). Otherwise enter 'N/A'.
- 4b. **Address of Institution:** Enter address of institution, if injury occurred in an institution.
- 4c. **Location of Injury Code:** Enter appropriate code for location within institution where injury occurred:

(1) Patient's Room	(6) Special Procedure Room
(2) Labor and Delivery Room	(7) Nursery
(3) Operating Room	(8) Radiology
(4) Recovery	(9) Physical Therapy Department
(5) Critical Care Unit	

Applicable only when 2f. is coded 1 or 4, otherwise enter 'N/A'.

- 5a. **Name of Injured Person:** Enter name of injured person.
- 5b. **Date of Birth:** Enter injured person's date of birth..
- 5c. **Sex:** Enter sex of injured person as 'M' (male) or 'F' (female).
- 5d. **Address:** Enter complete address of injured person.
- 6a. **Plaintiff Attorney's Name:** Enter name of attorney.
- 6b. **Plaintiff Attorney's Firm:** Enter firm of attorney.
- 6c. **Plaintiff Attorney's Address:** Enter address of attorney.
- 7a. **Nature and Substance of Claim:** Give a complete description of all actions and circumstances causing the claim. Include allegations made by claimant. Provide information on other healthcare professionals involved in the claim or having alleged liability for the injury.
- 7b. **Severity of Injury Code:** Enter severity of injury from scale provided below. Code principal injury if several injuries are involved:

<u>Duration</u>	<u>Severity of Injury Scale</u>	<u>Examples</u>
Temporary	(01) Emotional Only	Fright, no physical damage
Temporary	(02) Insignificant	Lacerations, contusions, minor scars, rash. No delay.
Temporary	(03) Minor	Infections, mis-set fracture, fall in hospital. Recovery delayed.
Permanent	(04) Major	Burns, surgical material left, drug side effect, brain damage. Recovery delayed.
Permanent	(05) Minor	Loss of Fingers, loss or damage to organs. Includes nondisabling injuries.
Permanent	(06) Significant	Deafness, loss of limb, loss of eye, loss of one kidney or lung.
Permanent	(07) Major	Paraplegia, blindness, loss of two limbs, brain damage.
Permanent	(08) Grave	Quadriplegia, severe brain damage,

- 7c. **Act or Omission Codes:** Identify the relationship to claim: 1 life long care or fatal prognosis. Medication, Intravenous anc (09) Death Equipment/Product, Miscellaneous. Enter the appropriate three-digit omission code. Use the MMPR Act or Omission Codes (Old Format MMPR) available from the NPDB.
- 8a. **Date Early Offer Requested:** Enter the date an Early Offer request was made of the Insured or Provider.
- 8b. **Date Early Offer Made:** Enter Date you responded with an early offer amount.
- 8c. **Date Early Offer Declined:** Enter Date
- 8d. **Early Offer Amount of Request:** Enter Amount
- 8e. **Early Offer Amount Offered:** Enter Amount
- 8f. **Early Offer Amount Paid:** Enter Amount Paid if the Early Offer was accepted
- 9a. **Reserve Amount for Indemnity:** Enter amount.
- 9b. **Reserve Amount for Expense:** Enter amount.
- 9c. **Date of Payment or Closure:** Enter amount.
- 9d. **Indemnity paid by you on behalf of this defendant:** Enter indemnity paid you on behalf of this defendant. If more than one policy is involved, total the amounts paid by you under all policies.
- 9e. **Loss adjustment expense paid to defense counsel:** Enter loss adjustment expense paid to defense counsel for this defendant.
- 9f. **All other allocated adjustment expense paid:** Enter all allocated loss adjustment expense paid for this defendant. Include filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.