formerly known as

Notice of Claim Form

Confidential Insurance Company Document
Prepared in Anticipation of Litigation

Complete this Document in its entirety and mail to Advocate, MD Insurance of the Southwest Inc. along with all legal notices and/or letters of any kind and a copy of the medical records. Please forward to:

Advocate, MD
Attention: Claims Department
811 Barton Springs Road, Suite 800
Austin, TX 78704
(512) 275-1855 Fax
brenda.freeman@advocatemd.com

Insured's Information

Insured's Name: ____________________________ Policy Number: ____________________

Entity's Name (If Applicable):____

Address: ____________________________ Telephone Number: (_____)______________

____________________________ Cellular Number: (______)________________

Notice you received (check one below) AND date received: ________________

_____ Deposition Notice   _____ Lawsuit/Legal Papers   _____ Letter of Intent

_____ Medical Board Inquiry   _____ Precautionary Notice   _____ Record Request

_____ Written Demand

Patient Information

Name:______________________________________ Sex:__________ Age:__________

Marital Status:__________________ Occupation:___________________________________

Treatment Dates:_____________ to _______________ Medical Records Enclosed: Yes_____ No_____

Location of Treatment:__________________________ PL_________ GL_________

Insurance:____

Attorney Representing Patient:____

Advocate MD[SM] Medical Professional Liability Insurance formerly known as MMAP Mississippi Medical Malpractice Plan

Allegations stated if any:____

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Describe in the first person treatment rendered by you and others, and the outcome:

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List other treating physicians, healthcare providers and hospitals, or other medical locations:

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Insured's Signature:____ Date:___________________________

KEEP THIS AND ALL RELATED MATERIAL IN A SEPARATE LEGAL FILE. DO NOT FILE THIS REPORT OR MAKE REFERENCES TO IT IN THE PATIENT'S MEDICAL RECORD OR ANYWHERE ELSE. CALL ADVOCATE, MD CLAIMS DEPARTMENT WITH ANY QUESTIONS YOU HAVE: (800) 686-2734.