*Send completed forms to claimintake@mpie.org or fax to 616-317-5990

Required Fields

CLAIMS INTAKE - FIRST REPORT OF NEW INCIDENT OR CLAIM

Please indicate one of the following: ◯ LAWSUIT ◯ NOTICE OF INTENT ◯ CLAIM ◯ INCIDENT ◯ DEP ◯ STATE INVESTIGATION

Policy Number:	Have you reported this matter to another insurer? ☐ Yes ☐ No

INSURED INFORMATION

Contact Person/ Reported by:	**Name:**	**Phone/Email:**	**Date of Report:**
Insured Group/ Facility Name:			
Event Location:			

Insured Provider(s):

Name	Specialty	Phone	Email

Non-Insured Provider(s):

Name	Specialty	Employer	Insurer

What date did you first become aware of this claim? Has this matter been reported previously to MPIE? ◯ Yes ◯ No Have you reported this matter to another insurer? ◯ Yes ◯ No	If you were served with a summons and complaint or NOI, list the date you received it and the manner you were served.

CLAIMANT INFORMATION

Patient Name:		**DOB:**	
Street Address:		City/Zip:	
Phone Number: (if applicable)		**SSN:**	
Occupation:		Married?	
# Dependents:		**Date of Loss:**	
Patient Email Address:		**Medicare Recipient?**	YES ◯ NO ◯

PATIENT TREATMENT AND INJURY SUMMARY

This report should be limited to the general summary of the insured's treatment of the patient. Discussions of standard of care and causation will be the duty of the Claims Manager at MPIE and defense counsel, if applicable.

Reason for Referral/Care Concern:			
Reason for Treatment:			
Date of First Treatment:		Date of Last Treatment:	

Description:	
Actions taken to date to address/resolve situation:	
Payment Issues (if applicable):	
Instructions to MPIE:	

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and may be subject to fines and confinement in prison.

RESET