REPORT CLAIMS to:
phyclaims@bbprograms.com
888-239-2663 (facsimile)

HEALTH CARE PROFESSIONAL LIABILITY COVERAGE PART
PHYSICIANS SURGEONS CLAIMS REPORTING FORM

Broker/Agent:____ Date of Notice:__________
Contact Name:____
Phone No.: ____
Email address:____

TYPE of INCIDENT/INJURY:

Incident Notice Only ______ Notice of Intent ______ Lawsuit _____ Board Action______

POLICY INFORMATION:

Policy No:____ Date of Incident:__________
Effective Dates: ______________________ To ____
Retroactive Date: ____
Limits:____

INSURED INFORMATION:

Insured:___________________________Phone No:_______________ Cell No: ___________________________

Email address:____

Mailing address:____DOB:_________________
State(s) of Practice:____

REPORT CLAIMS to:
phyclaims@bbprograms.com or
888-239-2663 (facsimile)

CLAIMAINT INFORMATION:

(Provide as much information as possible)

Claimant's Full Name: ____
Address: ____
Gender: ____
DOB: ____
Social security number: ________- _____- _________ (minimum of last 5 digits needed)

CLAIM INFORMATION:

Date of Insured's First Notice: ____
Date of Incident: ____

Place of Incident: ___________________ City/State __________________

Date Patient FIRST SEEN: ____

Date Patient LAST SEEN: ____

Brief Description of Loss:____
____
____
____
____
____
____