North Carolina Medical Board

MEDICAL MALPRACTICE PAYMENT REPORT
ADDITIONAL INFORMATION FOR NCMB

Claim Number: ______________________ Date & Amount of Payment: ______________________

Physician: __________________________ Physician DOB: ________________ Specialty: ________________

Patient Name: _______________________ Patient DOB: ________________ Date of Incident: ______________

Name of hospitals or other health care institutions in which patient received treatment: ______________________________

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Other physicians named in this case: ____

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Narrative Summary of Incident: (**Attach NPDB Form**)

Attach Expert Witness Reviews (Per NCGS § 90-14.13.)

Name, Address, and Telephone Number of Plaintiff's Attorney: ____

____

Liability: Clear: ☐ None: ☐ Questionable: ☐

Basis: ____

____

Is this physician aware of the claim payment? Yes ☐ No ☐

Was the payment made with the physician's approval? Yes ☐ No ☐

Insurance Company Name: ____

Address: ____

Prepared by: ________________________________ Date: ___________________________

Title: ____________________________________ Telephone: ___________________________

(Updated March 2024)

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