NORTH CAROLINA MEDICAL BOARD
P.O. Box 20007, Raleigh, NC 27619-0007
(919) 326-1100 [ext 220]

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:

_____

Other physicians named in this case:

_____

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 May 2005)