

# HOW TO REPORT A DENTAL CLAIM

Professional Solutions Insurance Company (Professional Solutions) is always ready to help you resolve an incident, situation that causes concern or a claim as fast and efficiently as possible. Through our confidential Claims Advice Hotline, Professional Solutions' policyholders can call and talk through any troubling situation or concern at no additional cost.

**Claims Reporting Line: 1-800-640-6504**

**Direct Dial: 515-313-(4 Digit Extension)**

**Toll Free Fax: 1-877-367-9654**

In the event that you are served with a claim, notice of a claim, lawsuit or incident, you should report it immediately to PSIC using the Report of Claims form. This includes, but is not limited to, records requests from attorneys\* or any notice received from your licensing board.

## Your Claims Contacts

Joel Kautz | *Director of Claims*

Ext. 4642

[jkautz@psicinsurance.com](mailto:jkautz@psicinsurance.com)

Keith Henaman | *Vice President of Claims*

Ext. 4552

[khenaman@psicinsurance.com](mailto:khenaman@psicinsurance.com)

## Information Needed

- Insured's name, policy number, phone numbers (office, mobile, and/or pager, and preferred method of contact), preferred mailing address, fax number and email address
- Patient name and nature of claimed injury (if known)
- Date and address of alleged incident
- Dental records
- The lawsuit or nature of the claim (if a lawsuit has been served, please provide date of service and who was served)
- Clinic name and address where your treatment took place

Please secure all patient records (including treatment, financial, and imaging) and DO NOT alter, modify or destroy them in any way.

### Mailing Address:

Professional Solutions  
Attn: Dental Claims Department  
PO Box 9118  
Des Moines, IA 50306-9118

### Overnight Mailing Address:

Professional Solutions  
Attn: Dental Claims Department  
14001 University Avenue  
Clive, IA 50325

### Email:

[Dentalclaims@psicinsurance.com](mailto:Dentalclaims@psicinsurance.com)



\* You do not need to report routine records requests received in the normal course of your practice. Our primary interest is records requests where an adverse event, outcome or dissatisfaction with care has occurred, causing concern that legal action could arise against you or your practice.

# REPORT of CLAIMS

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Alleged Date of Injury: \_\_\_\_\_

First Date of Treatment: \_\_\_\_\_ Last Date of Treatment: \_\_\_\_\_

Patient Home Address: \_\_\_\_\_

\_\_\_\_\_

## CLAIM INFORMATION

Lawsuit filed?  Yes  No If yes, date and manner of service: \_\_\_\_\_

Insured(s) named in claim: \_\_\_\_\_

\_\_\_\_\_

Nature of alleged injury (if known): \_\_\_\_\_

\_\_\_\_\_

**Please attach complete copies of all documents served upon you.**

## INSURED(S) CONTACT INFORMATION

Please provide the following for each insured named in the claim (if additional space is needed, please attach a separate sheet of paper):

Preferred mailing address for all future correspondence:

\_\_\_\_\_

\_\_\_\_\_

Email address: \_\_\_\_\_

\_\_\_\_\_

### Telephone contact #s:

Office: \_\_\_\_\_ Fax: \_\_\_\_\_

Mobile: \_\_\_\_\_ Home: \_\_\_\_\_

Pager: \_\_\_\_\_

Preferred method of contact: \_\_\_\_\_

Any person who knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.  
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