

# HOW TO REPORT A CLAIM

PSIC is always ready to help you resolve an incident or claim as fast and efficiently as possible. Through our confidential Claims Advice Hotline, PSIC policyholders can call and talk through any troubling situation or concern at no additional cost.

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

**Toll Free Phone: 1-800-640-6504**

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

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

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Keith Henaman   Vice President of Claims	Ext. 4552	khenaman@psicinsurance.com

## INSURED'S NEEDED INFORMATION

- 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 identification and nature of claimed injury (if known)
- Date, time and place of alleged incident
- Medical records
- The lawsuit or nature of the claim (if a lawsuit has been served, please provide date of service and who was served)

Please DO NOT make any additions or alterations to the medical records, and remember to place records (including x-rays, slides, etc.) in a secure location.

### MAILING ADDRESS:

PSIC  
Attn: Physician Claims Department  
PO Box 9118  
Des Moines, IA 50306-9118

### OVERNIGHT MAILING ADDRESS:

PSIC  
Attn: Physician Claims Department  
14001 University Avenue  
Clive, IA 50325

### EMAIL:

medicalclaims@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 when an adverse event, outcome or dissatisfaction with care has occurred, causing concern that legal action could arise against you or your practice.



# REPORT A CLAIM

## 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 numbers:

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. ©2020 PSIC NFL 9610-200764

