mpie
michigan professional insurance exchange

Required Fields

CLAIMS INTAKE - FIRST REPORT OF NEW INCIDENT OR CLAIM

Please indicate one of the following: ☐ **LAWSUIT** ☐ **NOTICE OF INTENT** ☐ **CLAIM** ☐ **INCIDENT** ☐ **DEP** ☐ **STATE INVESTIGATION**

Policy Number:	Have you reported this matter to another insurer? ☐ Yes ☐ No

INSURED INFORMATION					
Contact Person/ Reported by:		Contact #:		Date of Contact:	
Insured Group/Facility Name:					
Insured Provider Name:		Contact #:			
Email Address:		If you were served with a summons and complaint, on what date did you receive it?			
What date did you first become aware of this claim: ________________ Has this matter been reported previously to MPIE? ☐ Yes ☐ N Have you reported this matter to another insurer? ☐ Yes ☐ N					

CLAIMANT INFORMATION			
Patient Name:		DOB:	
Street Address:		City/Zip:	
Phone Number: (if applicable)		SSN:	
Occupation:		Married?	
# Dependents:		**Date of Loss:**	
Hospital MR#:		**Medicare Recipient ?**	**Yes** ☐ **No** ☐
Attorney Name and address (if applicable):			

PATIENT TREATMENT AND INJURY SUMMARY			
This report should be limited to the general summary of the insured's treatment of the patient. Discussions of standard of care and causation will be the duty of the Claims Manager at MPIE and defense counsel, if applicable.			
Reason for Referral/Care Concern			
Reason for Treatment:			
Date of First Treatment:		Date of Last Treatment:	
Description:			

Upon completion please send via email to ClaimIntake@mpie.org or fax to 616-741-1999

Actions taken to date to address/resolve situation:	
Payment Issues (If applicable):	
Instructions to MPIE:	