MANDATORY HEALTH CARE PROVIDER CLAIM
INFORMATION REPORT FORM
INITIAL REPORT

I. K.S.A. 40-3421 requires the following information to be submitted to the appropriate Kansas state health care provider regulatory agency and the Kansas Health Care Stabilization Fund no later than 30 days following the insurer's receipt of written or oral notice of claim.

1. Full Name of Claimant: _____

2. Names of Insured Health Care Provider: _____

3. Address: _____

4. Area of Practice or Specialty (describe or use current ISO rating classification):
_____

5. Kansas License Number of Health Care Provider: _____

6. Policy Coverage: _____
   a. Insurance Company Name: _____
   b. Policy Number: _____
   c. Policy Period: _____
   d. Policy Type: Claims Made _____ Occurrence _____
   e. Insurance Company Claim Number: _____

7. Date of Occurrence Giving Rise to Claim: _____

8. Date Occurrence Reported to Insurer: _____

9. Nature of Claim (Check One): _____ Oral _____ Written _____ Suit Filed

10. Date Suit Filed, If Any Was Initiated: _____

II. Mail Completed Form To:

1. The Appropriate State Health Care Provider Regulatory Agency, and
2. Kansas Health Care Stabilization Fund
   300 S. W. 8th Avenue, 2nd Floor
   Topeka, KS 66603-3912

- **A civil fine of up to $1,000 per day and suspension, revocation, denial of renewal or cancellation of insurer's Certificate of Authority to transact business in Kansas or Certificate of Self-Insurance may result for failure to report the information requested on this form. K.S.A. 40-3421(d).**