

Liability Claim Reporting Form

- 1) All claims should be reported as soon as possible. To report, complete this form and submit by email to [SHA Claims](#)
 2) Keep a copy of the completed Liability Claim Reporting Form for your records.

Incident Details/Claim Information

Date of Incident (dd/mm/yyyy) <input style="width: 95%;" type="text"/>	Facility/Location of Incident/Loss <input style="width: 95%;" type="text"/>	
Street Address <input style="width: 95%;" type="text"/>	City/Town <input style="width: 95%;" type="text"/>	Postal Code <input style="width: 95%;" type="text"/>
Name of Patient/Claimant <input style="width: 95%;" type="text"/>	Patient/Claimant Date of Birth (dd/mm/yyyy) <input style="width: 95%;" type="text"/>	
If a minor, Name(s) of Patient's/Claimant's Parent(s) <input style="width: 95%;" type="text"/>		

Description of the Incident/Claim

Enclosures: No Yes:

Most Responsible Leader(s)

Name <input style="width: 95%;" type="text"/>	Title/Position <input style="width: 95%;" type="text"/>	Daytime phone number <input style="width: 95%;" type="text"/>
Name <input style="width: 95%;" type="text"/>	Title/Position <input style="width: 95%;" type="text"/>	Daytime phone number <input style="width: 95%;" type="text"/>

Reporter Information

Name <input style="width: 95%;" type="text"/>	Title/Position <input style="width: 95%;" type="text"/>	Daytime phone number <input style="width: 95%;" type="text"/>
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Insurance Services – OFFICE USE ONLY

Claims Management Business Partner <input style="width: 95%;" type="text"/>	Date Incident/Claim Reported to Insurance Services (dd/mm/yyyy) <input style="width: 95%;" type="text"/>
Claim: <input type="checkbox"/> Potential <input type="checkbox"/> Actual: Plan: <input type="checkbox"/> Main <input type="checkbox"/> Partners <input type="checkbox"/> EMS <input type="checkbox"/> Foundations	Date Statement of Claim/Notice of Action/Demand Issued (dd/mm/yyyy) <input style="width: 95%;" type="text"/> <input type="checkbox"/> Not yet served