Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Ste 330
Wakefield, MA 01880

MA PROFESSIONAL LIABILITY INSURANCE REPORT OF CLOSED CLAIM - PLICC

Report Date: ____ / ____ / ____

☐ Check here if this form amends a previously filed Form PLICC

I. Reporting Insurer

Name of Insurer:____

Individual to contact, if necessary: ____

Telephone #: __________________________

II. Physician Information

Name: ____

Office Address: ____

____

Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___

Policy #: ________________________________

Massachusetts Medical License #: ____________________

III. Claim Information

Date When Claim Arose (Incident Date): ____ / ____ / ____ [to ____ / ____ / ____]

Date Claim Closed: ____ / ____ / ____

Incident Place Code (Circle one.):

01 Emergency Room	02 Labor/Delivery	03 Laboratory/X-Ray/Testing
04 Operating Room	05 Outpatient	06 Patient Room
07 Hospital-Other	08 Hospital-Unknown	09 HMO
10 Clinic	11 Nursing Home	12 Physician's Office
13 Walk-In Center	16 ICU	14 Other:__________________________

Name of Facility (if applicable):____

Physician's Role (Circle one.):

01 Anesthesiologist	08 PGY 7	02 Primary Care Physician
03 Referring Physician	09 PGY 6	04 Attending Physician
05 Consultant Specialist	10 PGY 5	06 Surgeon
07 Fellow	11 PGY 4	22 Acupuncturist
23 Administrator/Supervisor	12 PGY 3	24 Group Practitioner/Partner
26 On-Call Physician	13 PGY 2	27 Workmen's Comp Evaluator
28 Court Psychiatrist	14 PGY 1	98 Other: _____________________

Nature and Substance of Claim (Summarize; provide up to 8 basis codes from the attached table.):

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Basis Code: ___ ___ ___ Basis Code: ___ ___ ___ Basis Code: ___ ___ ___ Basis Code: ___ ___ ___

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Was a lawsuit filed in relation to this claim (Y*/N)? : ________

*If yes, supply the following information:

Venue (Circle one.):

01 Barnstable	02 Berkshire	03 Bristol	04 Dukes	05 Essex
06 Franklin	07 Hampden	08 Hampshire	09 Middlesex	10 Nantucket
11 Norfolk	12 Plymouth	13 Suffolk	14 Worcester	50 Federal
99 Out of State				

Docket #: ____________________________

Case Name: ____

_____ Check here if a trial was held before a judge only (no jury).

Final Disposition of Claim (Check as many as apply; indicate amount of judgment or settlement below, if applicable.):

_____ Defense Verdict

_____ Plaintiff Verdict

_____ Appeal by Defense

_____ Appeal by Plaintiff

_____ Voluntary Dismissal

_____ Settled by Other Defendant

_____ Lack of Prosecution

_____ Summary Judgment for Defense

_____ Summary Judgment for Plaintiff

_____ Settled

_____ Structured Settlement

_____ Other (Explain) ___________________________

Total Award/Judgment/Settlement*: $ ___, ___ ___ ___, ___ ___ ___

Interest on Award/Judgment/Settlement: $ ___, ___ ___ ___, ___ ___ ___

Amount Allocated to Physician: $ ___, ___ ___ ___, ___ ___ ___

Interest on Contribution: $ ___, ___ ___ ___, ___ ___ ___

*If Structured Settlement/Payment:

Present Value: $ ___,___ ___ ___, ___ ___ ___

Amount per Year: $ ___,___ ___ ___, ___ ___ ___

Number of Years: _________

Other Details:____

IV. Claimant/Plaintiff

Claimant/Plaintiff Name: ____

Address: ____

____

Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___

Date of Birth: ____ / ____ / ____

V. Additional Defendants

Name: ____

License #: ____________________

Office Address: ____

____

Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___

Name: ____

License #:____________________

Office Address: ____

____

Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___

Name:____

License #: ____________________

Office Address: ____

__________-____

Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___

Name:____

License #: _____________________

Office Address: ____

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Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___