FIRST REPORT OF CLAIM

PLEASE EMAIL THE FIRST REPORT OF CLAIM AND ANY ASSOCIATED DOCUMENTS TO: CLAIMS@BETAHG.COM

NAME OF MEMBER/INSURED:	CLAIM REPORTED BY (NAME/POSITION):
REASON FOR REPORT: ☐ INCIDENT ☐ CLAIM ☐ LAWSUIT DETAILS OF CLAIM (DATE RECEIVED AND/OR SERVED):	

CLAIMANT/INJURED PARTY INFORMATION

CLAIMANT/INJURED PARTY:	DATE OF BIRTH:	GENDER:	MARITAL STATUS:
SSN AND/OR MEDICARE BENEFICIARY IDENTIFIER #:			

EVENT INFORMATION

DATE OF EVENT:	WITNESS(ES):
DESCRIPTION OF EVENT/INJURIES SUSTAINED:	
CURRENT STATUS OF PATIENT (IF KNOWN):	
FOR PREMISES LIABILITY CASES, WAS THE INJURED PERSON TREATED AT THE MEMBER FACILITY? ☐ YES ☐ NO	
ARE THERE ANY VIDEOS, SECURITY REPORTS OR INCIDENT REPORTS REGARDING THIS INCIDENT? ☐ YES ☐ NO	
PLEASE INDICATE ATTACHMENTS (E.G., CLAIM, MEDICAL RECORDS, INCIDENT REPORTS):	

RISK MANAGEMENT

WAS THE MEDICAL RECORD ACCURATE, UP TO DATE AND AVAILABLE INCLUDING NECESSARY LABORATORY RESULTS, IMAGING, AND TEST RESULTS?

WAS THERE SOMETHING THAT PREVENTED INFORMATION FROM BEING COMMUNICATED EFFECTIVELY TO THE ENTIRE TEAM IN A TIMELY MANNER TO INCLUDE MISSING OR DELAYED RESULTS, FILMS OR OTHER INFORMATION THAT WOULD HAVE BEEN IMPORTANT TO MAKE A DECISION ABOUT CARE?

WAS THE PHYSICAL ENVIRONMENT CONDUCIVE TO PROVIDING SAFE CARE FOR THIS PATIENT/PROCEDURE/EVENT (E.G., LIGHTING, OVERHEAD PAGING, SECURITY, UNEVEN OR SLIPPERY SURFACES, VISITORS, EMERGENCY POWER, NOISE, ALARM FATIGUE)?

IDENTIFY THE ACTUAL STAFFING RATIO. WAS IT ADEQUATE?

DID THIS EVENT TAKE PLACE DURING A PROCEDURE, TEST, OR SKILLED TASK?

a. IF YES, HOW OFTEN ARE THESE PARTICULAR COMPETENCIES ASSESSED?
b. IF YES, IS THERE A WRITTEN PROTOCOL THAT THE CARE PROVIDER COULD HAVE REFERENCED?
   i. IF YES, WAS IT EASILY ACCESSIBLE AND DID THE CARE PROVIDER KNOW IT WAS AVAILABLE?
   ii. IF NO, WHERE WAS IT LOCATED? IS IT COMMONLY REQUESTED? COMMONLY USED?