Wyoming Health Care Malpractice Report For Individual Claims

Print Form

This information is required in accordance with Wyo. Stat. § 26-3-124 and is due by March 1 of each year. File one report for each claim with the Wyoming Insurance Department, 106 East 6th Avenue, Cheyenne, WY 82002.

See Instruction Pages — Please Type

☐ Initial Claim Report ☐ Status Report for Previously Filed Claim Remaining Open at Previous Year-End

1. Name of Insurer		2. NAIC Co. Code	3. Insurer Claim No.
4. Policy Limits	5. Date of Injury (Loss)	6. Date Reported to Insurer	7. Injured Person's Age

8. City of Injury	9. Malpractice Code	10. Injury Code	11. Profession Code	12. Specialty Code

13. Brief Description of Nature and Substance of Claim:

COMPLETE FOLLOWING SECTION ONLY UPON FINAL DISPOSITION OF CLAIM

14. Date Claim was Closed:

15. Case filed with Medical Review Panel? If yes, answer 16.	16. Panel Decision: Reasonable probability of malpractice?	17. Court Case filed?
Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Other ☐	Yes ☐ No ☐ Unknown ☐

18. Disposition of Claim:

- ☐ Arbitration
- ☐ Mediation
- ☐ Settlement
- ☐ Verdict in Favor of Insured Amount: _____
- ☐ Verdict in Favor of Insurer
- ☐ Judgment in Favor of Insured
- ☐ Judgment in Favor of Insurer
- ☐ Other _____

19. Total Amounts Paid:

- Medical & Prescription Costs _____
- Economic Damages _____
- Noneconomic Damages _____
- Defense Attorney Fees, Costs & Expenses _____
- Other _____

Total Amount Paid on this Claim _____

20. Source of Payment:

- ☐ Insurer
- ☐ Insured (Defendant)
- ☐ Other (Explain) _____

21. Were there codefendants? Yes ☐ No ☐ Unknown ☐
Insurer of each codefendant if known:

Contact Name (Last, First)	Contact Mailing Address
Contact Phone Number & E-Maill Address	Signature of Person Responsible

Instructions for Wyoming Malpractice Report Form

1. **Name of Insurer:** Enter name of company reporting this claim.
2. **NAIC Co. Code:** National Association of Insurance Commissioner's code assigned to all insurance companies.
3. **Insurer Claim No.:** Assign a distinguishing claim file identification number to each claim report. This number must be sufficient to enable tracking of a particular claim from the initial report through the time it is finally closed.
4. **Date of Injury (Loss):** Date alleged injury occurred**.**
5. **Date Reported to Insurer:** Date when claim was first reported to insurer and claim opened.
6. **Policy Limits:** Enter amount of policy limits.
7. **Injured Person's Age:** List age of injured party.
8. **City or Town:** City or town where injury occurred.

9. **Malpractice Code:**

MP	Mistake in Performance, Improperly Performed
DP	Delayed
NP	Not performed
WP	Wrong Procedure, Procedure not Indicated
BP	Better Alternative Available
OP	Other Procedural Errors, Including Erroneous Prescription of Medication
FD	Failure to Diagnose
DD	Delayed Diagnosis
WD	Wrong Diagnosis
OD	Other Diagnostic Errors
IO	Failure to Inform, Lack of Informed Consent
SO	Lack of Supervision
PO	Failure to Prevent Harm
OO	Other Cause(s) not Listed Above

10. **Injury Code:**

DTH	Death (e.g. fetal death, death of patient)
NPh	Non-Physical (e.g., abandonment, breach of contract, deposition, emotional distress, defamation, negligent referral, subrogation, loss of consortium, sexual misconduct)
BnD	Bone Damage (e.g. fracture)
Bth	Birth Injury (e.g., complications, brain damage to newborn, abortion problems)
Crc	Circulatory Injury (e.g., heart failure, hemorrhage)
Dis	Disease (e.g., AIDS, cancer)
DLE	Diminished Life Expectancy (e.g., usually from failure to diagnose)
Dsf	Disfigurement (e.g., scars)
Drm	Dermal Injury (e.g., burns)
Dnt	Dental Injury (e.g., broken tooth)
DLU	Diminished Use/Loss of Use (e.g., disablement of a limb, but not loss of the limb)
FnB	Foreign Body (e.g., left after surgery)
Inf	Infection (e.g., usually resulting from surgery)
LLO	Loss of Limb/Organ (e.g., amputation, removal)
MLI	Muscular/Limb Injury (e.g. atrophy)
Nrv	Nervous System (e.g., paralysis, nerve damage)
Org	Organ Injury (e.g., perforation, rupture)
Opt	Optical/Sensory Injury (e.g., vision, hearing)
PAN	Pain
Prl	Prolonged (e.g., additionl care, delayed recovery)
Rpr	Reproductive System (e.g., infertility)
SdE	Side Effects (e.g., reactions)
Wrg	Wrong Organ Removed, Injury Caused by Unnecessary Treatment
Note:	**If other injury, select one of the above codes that has the closest match**

11. **Insured's Profession Code:** Please list one of the following codes.

PC100	Physician, Surgeon, Osteopath
PC105	Hospital
PC110	Physician's Assistant, Nurse Practitioner
PC115	Nurse
PC120	Nursing Home
PC125	Dentist
PC130	Pharmacy
PC135	Pharmacist
PC140	Optometrist
PC145	Chiropractor
PC150	Clinic/Corporation

PC155	Ambulance Service
PC160	Emergency Medical Technician
PC165	Laboratory
PC170	Dietician/Nutritionist
PC175	Podiatrist
PC180	Psychologist/Psychiatrist
PC185	Physical/Rehabilitative Therapist
PC190	Respiratory Therapist
PC195	Other (identify)

12. **Insured's Specialty Code:** Please list one of the following codes.

SP200	Internal Medicine
SP205	Family Physician/General Practitioner
SP210	Emergency Medicine
SP215	Obstetrics/Gynecology
SP220	Surgery (Neuro)
SP225	Surgery (Orthopedic)
SP230	Surgery (Cosmetic)
SP235	Surgery (General/Other)
SP240	Radiology/Oncology
SP245	Anesthesiology
SP250	Neurology

SP255	Cardiovascular Disease
SP260	Pulmonary Diseases
SP265	Gastroenterology
SP270	Pediatrics
SP275	Urology
SP280	Ophthalmology
SP285	Dermatology
SP290	Allergy/Immunology
SP295	Psychiatry
SP300	Other (identify)

13. **Brief Description of nature & substance of claim:** Self-explanatory.
14. **Date Claim was Closed?** Date claim was finally disposed of.
15. **Was case filed with Medical Review Panel?** (Check yes, no or unknown).
16. **Panel Decision: Is there reasonable probability of malpractice?** Check yes, no or other (i.e. claim settled/withdrawn prior to decision).
17. **Was court case filed?** Check yes, no or unknown.
18. **Disposition of claim:** Check appropriate box. **If a jury verdict was rendered, fill in amount of verdict, regardless of whether amount was later settled or amended through appeal or otherwise.**
19. **Amounts paid:** Break down the total amount paid between medical and prescription costs; economic damages other than medical; noneconomic damages (i.e. pain and suffering & other punitive damages) attorney fees, costs and expenses; any other costs that do not fit those categories and, total amount paid on claim (column adds automatically).
20. **Source of payment:** Specify if by insurer, insured or other (may be a combination of both, or partially from other codefendants).
21. **Were there codefendants?** Check yes, no or unknown, and list name of insurer of each codefendant if known.