



Notice of Claim Form

Confidential Insurance Company Document
Prepared in Anticipation of Litigation

Complete this Document in its entirety and mail to Advocate, MD Insurance of the Southwest Inc. along with all legal notices and/or letters of any kind and a copy of the medical records. Please forward to:

Advocate, MD
Attention: Claims Department
811 Barton Springs Road, Suite 800
Austin, TX 78704
(512) 275-1855 Fax
brenda.freeman@advocatemd.com

Insured's Information

Insured's Name: Policy Number:

Entity's Name (If Applicable):

Address: Telephone Number: ()
Cellular Number: ()

Notice you received (check one below) AND date received:

- Deposition Notice Lawsuit/Legal Papers Letter of Intent
Medical Board Inquiry Precautionary Notice Record Request
Written Demand

Patient Information

Name: Sex: Age:

Marital Status: Occupation:

Treatment Dates: to Medical Records Enclosed: Yes No

Location of Treatment: PL GL

Insurance:

Attorney Representing Patient:



Allegations stated if any: _____

Describe in the first person treatment rendered by you and others, and the outcome:

List other treating physicians, healthcare providers and hospitals, or other medical locations:

Insured's Signature: _____ Date: _____

KEEP THIS AND ALL RELATED MATERIAL IN A SEPARATE LEGAL FILE. DO NOT FILE THIS REPORT OR MAKE REFERENCES TO IT IN THE PATIENT'S MEDICAL RECORD OR ANYWHERE ELSE. CALL ADVOCATE, MD CLAIMS DEPARTMENT WITH ANY QUESTIONS YOU HAVE: (800) 686-2734.