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STATE OF NEVADA

ROSE McKINNEY-JAMES
Director

ALICE A. MOLASKY, ESQ.
Commissioner of Insurance

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
Capitol Complex
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(702) 687-4270

BULLETIN 95-001

October 16, 1995

MEDICAL MALPRACTICE SETTLEMENT REPORT

NRS 690.045 requires insurers which provide liability insurance for a "practitioner" licensed pursuant to chapters 630 to 640 of NRS to file with the appropriate licensing board a report detailing the circumstances of the malpractice. The report to the licensing board is required only when the claim's settlement, award, or judgment is $5,000 or more.

Additionally, NRS 690B.050 requires a report to the Division of Insurance (Division) where the insured is a doctor of medicine licensed pursuant to chapter 630 of NRS. The report is required if a liability policy covering acts of professional malpractice exists, and if a settlement or award is made, or if a judgment is rendered.

It should be noted that there is **no minimum settlement** amount threshold under NRS 690B.050. All claims must be reported within 30 days of the close of the claim, whether or not any payment was made to the claimant. The reports made pursuant to NRS 690B.050 must be filed with the Division at the same time they are filed with the appropriate licensing board.

MEDICAL MALPRACTICE CLOSED CLAIMS REPORT

The Division has revised the report form required pursuant to NRS 690B.045 and NRS 690B.050. The new form is the NEVADA MEDICAL PROFESSIONAL LIABILITY REPORT FORM and is effective for claims closed on and after Novemeber 1, 1995.

For any questions concerning this report, please contact the property/casualty section of the Division at (702) 687-7682.

BULLETIN 86-002 is withdrawn.

ALICE A. MOLASKY, ESQ.
Commissioner of Insurance

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NEVADA MEDICAL PROFESSIONAL LIABILITY REPORT FORM

Report each claim closed on or after November 1, 1995. Submit a report for each defendant insured by filing insurer, including claims closed without payment. Complete all blocks on the form. If information is not applicable, enter "NA". When an item calls for a dollar amount and no amount is involved, enter 0 in the space after the $ sign. Record all amounts in whole dollars only, all dates as MM YY and all ages (on the date of occurrence) as YY. All sections of this form must be completed. If any sections are left incomplete, this form will be returned to you with a request to include the appropriate information.

1. Name of Insurer:_____ 2. Claim Number:_____

3a. Date of Injury:_____ 3b. Date Reported to Insurer:_____ 3c. Date of Closure:_____

4a. Insured's Name:_____

4b. Insured's Address:_____

5a. Board Certification: Yes ( ) No ( ) 5b. Specialty Code per ISO:_____

5c. Description:_____ 5d. Foreign Medical School Graduate: Yes ( ) No ( )

6a. Claimant's Name:_____ 6b. Age:_____ 6c. Sex:_____

6d. Claimant's Address:_____

7. Description of the Acts or Omissions and Injuries or Illnesses upon which the Claim or Action was Based:

_____

8a. Name of Institution (IF injury occurred in Institution):_____

8b. ISO Code:_____ 8c. City:_____ 8d. County:_____

9a. Co-Defendant Yes ( ) No ( ) 9b. If Yes, how many:_____

9c. Name of Co-Defendant(s) Insurer:_____

9d. Co-Defendant(s) Claim file Identification:_____

10a. Medical Dental Screening Panel Case Number:_____

10b. Medical Dental Screening Panel findings: (Check Appropriate Findings):

1.___No Malpractice 2.___Malpractice and Injury 3.___Unable to decide 4.___Settled before Panel met 5.___Dismissed by Panel

11a. Court Case Filed: Yes ( ) No ( ) 11b. If Yes, Filed in City & County of:_____

12. Case Value from Settlement Judge (if applicable):_____

13a. Binding Arbitration: Yes ( ) No ( ) 13b. Verdict Amount:_____

14a. Structured Settlement: Yes ( ) No ( ) 14b. Settlement Amount:_____ 14c. Date of First Payment:_____

15. Amount of Indemnity Reserve if Still Outstanding:_____

16. Amount of Loss Adjustment Expense Reserve if Still Outstanding:_____

17. Indemnity Paid by You on Behalf of Defendant:_____

18. Total Allocated Loss Adjustment Paid by You on Behalf of Defendant:_____

_____ _____

Contact Person and Telephone Number Name of Person Responsible for Report

_____ _____

Signature of Person Responsible for Report

_____

Address