# Oregon Negligence/Malpractice Claim Report Form

Oregon Board of Chiropractic Examiners
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ORS 742.400 requires malpractice insurers to submit claim information to the Oregon Board of Chiropractic Examiners within 30-days of notice to them, and again when the claim is resolved, including claims closed without payment. The form below should be completed for every claim received by the reporting entity. This form is designed for reporters to fill out electronically. Please send the printed, completed form to the Oregon Board of Chiropractic Examiners.

## Reporting Entity Information:

**Reporting Entity:** _____ **NAIC #:** _____ **Claim File ID:** _____

**Contact Person:** _____ **Phone #:** _____

**Mailing address:** **City:** **State:** **ZIP:**

## Covered Practitioner (Chiropractic Physician only):

License #: _____ Name: _____ Date of Birth: _____

Address: _____ Phone: ( )

City: _____ State: _____ Zip: _____

Board certified (code): Specialty (code): Other spec. (code):

## Injury/Incident Data:

Injured person's name: _____ Age: _____ ☐ M ☐ F

Date of injury: _____ Date reported to insurer: _____ If re-opened, date re-opened: _____

**Is Claim Court-Filed?** ☐ Yes ☐ No **If Yes, Date Filed in Court:** _____

Place where injury occurred (code): _____ City: _____ State: _____ Zip: _____

Name of clinic (if injury occurred in clinic): _____

Total defendants involved in claim: _____ Derivative claim (code): _____

Plaintiff attorney's name: _____ Address:

City: _____ State: _____ Zip: _____

Severity of injury (code): _____ Misadventures in procedures (code): _____ Misadventures in diagnosis (code): _____

Others contributing to injury (code): _____ Associated issues (code): _____ Coverage (code): _____

Companion claim file identification:

**Allegations and reasons for claim. State patient's actual, original, abnormal condition and any material diagnosis, procedure, planning error, medical injury or other allegation:** *(Please be as detailed as possible, attach page if needed.)*

## Closure Data:

Closure date: _____ Claim disposition (code): _____ Settlement (code): _____

Court (code): _____ Binding arbitration (code): _____ Review panel (code): _____

| | Economic | Non-economic | Punitive | Unspecific |
|---|---|---|---|---|
| Indemnity insurer paid on behalf of defendant: | $ | $ | $ | $ |
| Other indemnity paid by/on behalf of defendant: | $ | $ | $ | $ |
| Indemnity paid by all parties (for all defendants): | $ | Additional Comments: | | |
| Loss adjustment expense paid to defense counsel: | $ | | | |
| All other allocated loss adjustment expenses paid: | $ | | | |

OBCE Received Claim Date: _____

Submit Form

# SPECIFIC DATA FIELD INSTRUCTIONS

**NAIC NUMBER**: Enter the five-digit numeric company code supplied by the National Association of Insurance Commissioners. A convenient source *is* page 1 of the company statutory annual statement.

**NAME OF INSURER**: Enter complete name of specific company reporting this claim.

**CLAIM FILE IDENTIFICATION**: Enter whatever information necessary for your company to identify this claim if contacted concerning this report.

**LICENSE NUMBER**: Enter the license number assigned by the appropriate licensing board to the insured. Any prefix letters must be included.

**INSURED'S NAME**: Enter name of insured defendant, last name first.

**AGE**: Enter age of insured on date of occurrence.

**CITY**: Enter city where insured principally practiced at time of alleged injury. Street address is not required.

**STATE**: Enter state of insured, using two-letter postal abbreviation.

**ZIP**: Enter zip code of insured.

**PROFESSIONAL OR BUSINESS CODE**: Enter appropriate code for the named insured.

(1) Physician or surgeon
(2) Optometrist
(3) Dentist, oral surgeon, periodontist, orthodontist
(4) Dental hygienist
(5) Naturopath
(6) Other medical professional (please specify)

**SPECIALTY CODE**: If the insured has practiced under more than one specialty, select the specialty relating to this incident. Enter the appropriate five-digit specialty code from the IS0 Commercial Statistical Plan for medical professionals, expanded to include these additional codes:

| | |
|---|---|
| Chiropractor | 80410 |
| Naturopaths | 80404 |
| Podiatrists | 80993 |

Dentists:

| | |
|---|---|
| General Dentists, NOC | 80211 |
| Endodontists | 81211 |

| | |
|---|---|
| Oral Pathologists | 82211 |
| Oral Surgeons | 83211 or 80210 |
| Orthodontists | 85211 |
| Periodontists | 86211 |
| Prosthodontists | 87211 |

ISO: Insurance Services Office

**BOARD CERTIFICATION**: Enter appropriate code if insured is board certified in:

(1) Specialty coded in preceding space.
(2) A different specialty (also enter additional specialty code).
(3) Both-specialty coded in preceding item and another specialty (also enter additional specialty code).
(4) Insured is not board certified.

**OTHER SPECIALTY**: Enter code for any specialty in which insured is board certified, other than the previously coded specialty.

**TYPE OF PRACTICE**: Enter a code for the insured.

(1) Institutional (including academic)
(2) Professional Corporation or Partnership (Group)
(3) Self-employed
(4) Employed Physician
(5) Employed Nurse
(6) *All* Other Employees
(7) Intern or Resident

**FOREIGN MEDICAL GRADUATE**: Select "Y' (Yes) or "N" (No) for insured physician or surgeon only.

**COUNTRY**: If an insured is a physician or surgeon and a foreign medical graduate enter the country in which primary medical education was received. Otherwise, enter "NA".

**INJURED PERSON'S NAME**: Enter last name of injured person fist. In a case involving stillbirth, the name of the injured is "baby girl" (or boy) together with the last name of the parent. If a baby was liveborn but was injured or subsequently died, the newborn should be named as the insured person. If claims were made on behalf of both mother and newborn, file two reports.

**AGE OF INJURED PERSON**: Enter age of injured person on the date of injury. Enter an infant's age as "On. If exact age is unknown, but approximate age is known, enter approximate age and indicate as such.

**GENDER OF INJURED PERSON**: Select gender of injured person as "M (Male) or "F" (Female).

**DATE OF INJURY**: Enter two digits each for month and day, and four digits for year, of principal or alleged injury.

**DATE REPORTED**: Enter two digits each for month and day, and four digits for year, when the incident was first reported to you or registered as a claim.

**DATE REOPENED**: When reporting a reopened case, enter two digits each for month and day, and four digits for year, when case was reopened.

**PLACE WHERE INJURY OCCURRED**: Enter the appropriate code for the place where the principal injury occurred.

(1) Hospital Inpatient Facility
(2) Emergency Room
(3) Hospital Outpatient Facility
(4) Nursing Home
(5) Insured's Office
(6) Patient's Home
(7) Other Outpatient Facility (including industrial clinics, birth control clinics and abortion clinics)
Other Hospital/Institutional Locations (including elevator, hallway, lounge, office, hospital grounds)
Other (please specify)

If the claim resulted from a diagnostic error, code place where error occurred, regardless of where it was discovered or treated.

**CITY**: Enter city for place of injury.

**STATE**: Enter two-letter state postal abbreviation for place of injury.

**ZIP**: Enter zip for place of injury. If undeterminable, enter 3-digit community code and 2 zeros.

**NAME OF INSTITUTION**: Enter name of institution if injury occurred in an institution ("Place Where Injury Occurred should be coded 1, 2, 3, 4, 7 or 9). Otherwise, enter "NA.

**LOCATION OF INSTITUTIONAL INJURY**: Enter appropriate code for location within institution where injury occurred:

(1) Patient's Room
(2) Labor and Delivery Room
(3) Operating Suite
(4) Recovery Room

(5) Critical Care Unit
(6) Special Procedure Room
(7) Nursery
(8) Radiology
(9) Physical Therapy Department
(99) Not Applicable

This question is applicable only when "Place Where Injury Occurred" is coded 1 or 4. In all other cases, enter 99. Injuries occurring in the emergency room, hospital outpatient facility or other hospital/institutiona1 location are already identified as place of injury 2, 3 or 8.

**TOTAL DEFENDANTS INVOLVED IN CLAIM**: Enter total number of defendants (persons and institutions other than John Does) involved in claim.

**DERIVATIVE CLAIM**: Enter appropriate code if there was also a derivative claim (on behalf of someone other than the medically injured) made by:

(1) Spouse
(2) Children
(3) Parent
(4) Personal Representative

This question should be coded only on the report for the medically injured person. If more than one derivation claim is made, enter the code for the most significant claim.

**PLAINTIFF ATTORNEY'S NAME**: Enter complete name of plaintiff attorney, last name first.

**CITY**: Enter plaintiff attorney's city. Street address is not necessary.

**STATE**: Enter two-letter state abbreviation for plaintiff attorney's state.

**ZIP**: Enter plaintiff attorney's zip code.

**SEVERITY OF INJURY**: Enter severity of injury from scale provided below. Code principal injury if several injuries are involved.

| | **Severity of Injury Scale** | **Examples** |
|---|---|---|
| | (1) Emotional Only | Fright, no physical damage. |
| | (2) Insignificant | Lacerations, contusions, minor scars, rash. No delay. |
| Temporary | (3) Minor | Infection, missed fracture, fall in hospital. Recovery delayed. |
| | (4) Major | Burns, surgical material left, drug side effect, brain damage. Recovery delayed. |

| | | |
|---|---|---|
| | (5) Minor | Loss of fingers, loss or damage to organs. Includes nondisabling injuries. |
| | (6) Significant | Deafness, loss of limb, loss of eye, loss of one kidney or lung. |
| Permanent | (7) Major | Paraplegia, blindness, loss of two limbs, brain damage. |
| | (8) Grave | Quadriplegia, severe brain damage, lifelong care or fatal prognosis. |
| | (9) Death | |

**MISADVENTURES IN PROCEDURES**: Enter the appropriate misadventures code(s) if the procedure was:

(1) Not adequately indicated or unnecessary
(2) Contraindicated
(3) There was a more appropriate alternative
(4) Delayed
(5) Improperly performed
(6) Not performed
(7) Occasioned by misdiagnosis

For other health care personnel, enter the appropriate misadventures code(s) if any were factors in the claim:

(8) Inadequate assessment
(9) Misidentification of the patient
(10) Delay in notifying physician
(11) Failure to notice an improper order
(12) Failure to obtain a proper order
(13) Failure to instruct patient
(99) Not applicable

If the insured is a physician or surgeon, codes 1-7 or 99 only may apply. If another health care person is named as the insured in this report or 'if other health .care personnel are indicated as "others contributing", codes 1- 13 may be appropriate. Codes 8 through 13 are primarily intended to classify procedural misadventures of nursing personnel. Up to three codes can be entered.

**MISADVENTURES IN DIAGNOSIS**: Enter the appropriate code if any of the following misadventures in diagnosis caused or aggravated the injury. Enter the code for the major contributing misadventure if more than one is involved.

(1) Delay in diagnosis

(2) Misdiagnosis of an abnormal condition (including failure to diagnose)
(3) Misdiagnosis in the absence of an abnormal condition
(99) Not applicable

**OTHERS CONTRIBUTING TO THE INJURY**: Enter the appropriate code(s) for any person(s) other than the insured named in this report who caused or contributed to the injury, regardless of whether claim was filed against them. Do not enter a code for the insured. Up to three codes can be entered.

(1) Attending Physician
(2) House Staff
(3) Consultant
(4) Nurse, RN
(5) Nurse, LPN or LVN
(6) Aide
(7) Orderly
(8) Pharmacist
(9) Radiologist
(10) Radiology Technician
(11) Anesthesiologist
(12) Anesthetist
(13) Pathologist
(14) Laboratory Technician
(15) Physician's Assistant
(16) O.R. Technician
(17) Physical Therapist
(18) Inhalation Therapist
(19) Other Therapist
(20) Other Technician
(21) Dietician
(22) Maintenance Personnel
(23) Engineer
(24) Administrator
(25) Other Personnel
(26) Patient
(27) Another Patient
(99) Not Applicable

**ASSOCIATED ISSUES**: Enter the appropriate code(s) if one or more of the following factors were associated issues in the claim (up to three codes can be entered):

Legal Issues

(1) Abandonment
(3) False Imprisonment
(6) Breach of confidentiality
(9) Failure to conform to regulation or statutory rule
(13) Products liability
(16) Lack of consent from proper person
(17) Inadequate information for informed consent
(18) Procedure exceeded consensual understanding
(19) Breach of contract
(20) Warranty
(21) Assault and battery
(22) Res Ipsa Loquitur
(49) Vicarious liability
(50) Statute of limitations
(51) Punitive .damages

Other Associated Issues

(2) Premature discharge h m institution
(4) Lack or delay of consultation
(5) Lack of supervision
(7) Failure to prevent an abnormal condition
(8) Failure to accomplish intended *result*
(10) Lack of adequate facilities or equipment
(12) Pharmacy error
(14) Failure to timely disclose
(15) Failure to provide warning instructions
(46) Records
(47) Billing and collection
(48) Interprofessional relations

Maintenance and Operation of Equipment

(23) Emergency equipment
(24) Cooling devices
(25) Heating Devices
(26) Cautery Equipment
(27) X-ray equipment
(28) Radiation therapy equipment
(29) Traction equipment
(30) Anesthesia equipment
(31) Operative equipment
(32) Surgical instruments and materials
(33) Food preparation equipment
(34) Laboratory equipment

Laboratory

(11) Laboratory error (not otherwise classified)
(35) Laboratory mislabeling
(36) Laboratory computation error
(37) Laboratory inadequate specimen
(38) Laboratory lost specimen
(39) Laboratory interpretation
(40) Laboratory reporting error
(41) Laboratory delay in reporting

Infection Control Techniques

(42) Sterilization of equipment
(43) Skin preparation
(44) Aseptic technique
(45) Isolation for infection control

Not applicable

**COVERAGE CODE**: Enter the appropriate code for the type of policy covering the claim:

(1) Policy covers claims made during the term of the policy.
(2) Policy or endorsement covers claim made for events which occurred during a designated previous policy term.
Policy covers all claims whenever presented for events which occur during the policy term.

**COMPANION CLAIM FILE IDENTIFICATION**: Enter complete claim me identification numbers for all claims against other defendants or from other claimants involved in this same incident, regardless of whether your company or another insurer provided that coverage. If you do not know claim numbers from another insurer, enter the name of the insurer.

**ALLEGATION AND REASONS FOR CLAIM**: State patient's actual, original, abnormal condition and any material diagnosis, procedure or planning error, medical injury or other allegation.

Include any important aspects of this claim which cannot be clearly explained by the other information supplied on this form. Your response may change between the initial 30-day report and the closure report, when more is known about the claim. A final assessment of the patient's actual, original condition is necessary for statistical analysis of claims data.

If the patient's actual condition was misdiagnosed, resulting in improper treatment or failure to treat, describe the misdiagnosis. Example: Appendicitis might have been an initial diagnosis, but during surgery ectopic pregnancy was discovered. Appendicitis is the misdiagnosis; ectopic pregnancy is the actual original condition.

State any operation, diagnostic or treatment procedure which allegedly caused injury. If anesthesia or drugs are involved, give specific names and methods of administration.

**CLOSURE DATE**: Enter two digits each for month, day, and year of claim disposition. When reporting a reopened case, enter new closure date.

**CLAIM DISPOSITION**: For closed claims, enter && method of disposition:

(1) Settled by parties (including claims abandoned)
(2) Disposed of by a court (including dismissals)
(3) Disposed of by binding arbitration

**SETTLEMENT CODE**: Enter the appropriate code if claim was settled by agreement of parties;

(1) Before filing suit or demanding arbitration hearing
(2) Before trial or hearing
(3) During trial or hearing
(4) After trial or hearing, but before judgment or decision (award)
(5) After judgment or decision, but before appeal
(6) During appeal
(7) After appeal
(8) Claim or suit abandoned by plaintiff
(9) During review panel or nonbinding arbitration
(99) Not applicable

Enter "99" if claim was disposed of by court process or binding arbitration.

**COURT CODE**: Enter the appropriate court code:

(0) No court proceedings were initiated
(1) Directed verdict for plaintiff
(2) Directed verdict for defendant
(3) Judgment notwithstanding verdict for plaintiff (judgment for defendant)
(4) Judgment notwithstanding verdict for defendant (judgment for plaintiff)
(5) Judgment for plaintiff
(6) Judgment for defendant
(7) Judgment for plaintiff after appeal
(8) Judgment for defendant after appeal
(9) All others (including dismissals and claims settled after initiation of court proceedings)

**BINDING ARBITRATION CODE**: Enter appropriate binding arbitration code:

(0) Claim not subject to arbitration
(1) Claim subject to arbitration, but previously coded disposition reached in lieu of award; i.e. claim was settled "disposition" or disposed of by court process "disposition."
(2) Award for plaintiff
(3) Award for defendant

**REVIEW PANEL CODE**: If a review panel or screening panel was used as a preliminary action and there was some finding, enter: (1)) Finding for plaintiff; (2) Finding for defendant, or (99) not applicable. This item is completely independent of all other closure data. For the remaining items, record amounts in whole dollars only (drop cents). Enter "0" if no amount is involved. For the first two items only (payments on behalf of this defendant), distinguish amounts paid as (a) economic ("specific") damages; (b) noneconomic ("general") damages; or (c) punitive damages. If the amounts cannot be so distinguished, enter as all (b), noneconomic.

**INDEMMTY PAID BY YOU ON BEHALF OF THIS DEFENDANT**: If more than one policy is involved, total the amounts paid by your company under all policies (for this defendant only).

**OTHER INDEMNITY PAID BY OR ON BEHALF OF THIS DEFENDANT** Enter all indemnity paid by other parties on behalf of this defendant. If the amount represents payment under excess coverage by another insurer, check "E" box. If the amount represents a deductible retained by the insured, check "D" box. Do not enter indemnity paid on behalf of other defendants in this line.

**INDEMNITY PAID BY ALL PARTIES (FOR ALL DEFENDANTS)** Enter total indemnity paid by all parties on behalf of all defendants involved in this incident.

**LOSS ADJUSTMENT EXPENSE PAID TO DEFENSE COUNSEL** Enter loss adjustment expense paid by you to defense counsel for this defendant.

**ALL OTHER ALLOCATED LOSS ADJUSTMENT EXPENSE PAID BY YOU** Enter all other allocated loss adjustment expense paid by you for this defendant. Include filing fees, telephone charges, photocopy fees, expenses of defense counsel, etc.

**NAME OF CONTACT PERSON**: Provide the name, address and telephone number for the person to be contacted by the licensing boards or the Oregon Insurance Division regarding any apparent errors in this report.