APPLICATION FOR REVIEW OF CLAIM

To: Director, Montana Medical-Legal Panel
202l - Eleventh Avenue
Helena, MT 5960l

l. INFORMATION AS TO PARTIES.

A. CLAIMANT:

Name _____Telephone_____
Address _____
Status of Claimant (check one) __Patient __Other
Patient's Name if Different From Claimant: _____

B. CLAIMANT'S LEGAL COUNSEL:
Name _____Telephone_____
Address _____

C. HEALTH CARE PROVIDERS AGAINST WHOM CLAIM IS MADE: This claim is made against _____(#) Health Care Providers:

l. Name _____Telephone_____
Address_____

2. Name _____Telephone_____
Address_____

3. Name _____Telephone_____
Address_____

4. Name _____Telephone_____
Address_____

(If additional parties are involved, please attach a separate listing of their Names, Addresses, and Telephone Numbers under this category designation.)

D. OTHER NECESSARY AND PROPER PARTIES NOT DESIGNATED HEALTH CARE PROVIDERS: There are ____(#) other parties who are necessary or proper parties for any court action which might subsequently arise out of the same factual circumstances as set forth in this application:

l. Name _____

2. Name _____

(If additional parties are involved, please attach a separate listing of their Names under this category designation)

2. INFORMATION AS TO CLAIM.

A. SEPARATE SPECIFIC ACCOUNT OF CLAIM: On a separate sheet of paper, please set out in reasonable detail:

1. The elements of the health care provider's conduct (either acts or omissions or both) which are believed to constitute a claim of malpractice

2. The places and dates the acts or omissions occurred;

3. The names and addresses of all physicians, hospitals, or other health care providers having contact with the patient relative to the incident or incidents in question, including health care providers not named as parties to the claim, specifying whether such health care providers are parties to the claim or merely individuals or entities having had contact with the patient relative to the incident;

4. The names and addresses of all other witnesses to the incident in question.

B. CLAIM INFORMATION: For Panel purposes, even if the following information is provided in your separate specific account of the claim, please indicate as to the primary incident:

l. Date of Occurrence Of Incident: _____
2. Date Of Discovery Of Incident By Patient: _____
3. Place Of Incident:
   (a) County: _____
   (b) Location: (check one)
      (l) ____Doctor's Office
      (2) ____Hospital
      (3) ____Other (Please specify:_____)

3. AUTHORIZATION TO RELEASE INFORMATION: Please have the claimant sign and return (in duplicate) a completed consent form (FORM B) for each health care provider named in the claim as a party to the claim or named as otherwise having had contact with the patient relative to the incident even if not named as a party to the claim.

THE UNDERSIGNED, AS ___CLAIMANT ___CLAIMANT'S ATTORNEY, REQUESTS CONSIDERATION OF THE ABOVE CLAIM, INCLUDING ALL ATTACHED MATERIALS, BY THE MONTANA MEDICAL LEGAL PANEL, IN ACCORDANCE WITH MCA 27-6-101 ET. SEQ., THE MONTANA MEDICAL LEGAL PANEL ACT.

DATE: _____ _____(Signed Name)

_____(Typed/Printed Name)

FORM A - Revised May, l988.