North Carolina Medical Board

MEDICAL MALPRACTICE PAYMENT REPORT
ADDITIONAL INFORMATION FOR NCMB

Claim Number: ____________________ Date & Amount of Payment: ____________________

Physician: ____________________ Physician DOB: ______________ Specialty: ______________

Patient Name: ____________________ Patient DOB: ______________ Date of Incident: ______________

Name of hospitals or other health care institutions in which patient received treatment: ____________________

____

Other physicians named in this case: ____

____

Narrative Summary of Incident: (**Attach NPDB Form**)

Attach Expert Witness Reviews (Per NCGS § 90-14.13.)

Name, Address, and Telephone Number of Plaintiff's Attorney: ______________________________

____

Liability: Clear: ☐ None: ☐ Questionable: ☐

Basis: ____

____

Is this physician aware of the claim payment? Yes ☐ No ☐

Was the payment made with the physician's approval? Yes ☐ No ☐

Insurance Company Name: ____

Address: ____

Prepared by: ______________________________ Date: ______________________

Title: ______________________________ Telephone: ______________________

Completed forms can be submitted to: MalpracticeResponse@ncmedboard.org

(Last revised September 2024)

3127 Smoketree Court, Raleigh, NC 27604 | PO Box 20007, Raleigh, NC 27619
Tel: (919) 326-1100, Ext. 434 | Fax: (919) 326-1131 | www.ncmedboard.org