



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)