KANSAS MANDATORY HEALTH CARE PROVIDER CLAIM
INITIAL REPORT FORM

A. K.S.A. 40-3421 requires the following information to be submitted to the appropriate Kansas state health care provider regulatory agency and the Kansas Health Care Stabilization Fund no later than 30 days following the insurer's receipt of written or oral notice of claim.*

1. Full name of claimant: _____
2. Name of insured health care provider: _____
3. Address: _____
4. Area of practice or specialty (describe or use current ISO rating classification): _____
5. Health care provider's Kansas license number: _____
6. Policy coverage: _____
   a. Insurance company name: _____
   b. Policy number: _____
   c. Policy period: _____
   d. Policy type: claims made ☐ occurrence ☐
   e. Insurance company claim number: _____
7. Date of occurrence giving rise to claim: _____
8. Date occurrence reported to insurer: _____
9. Nature of claim (check one): ☐ oral ☐ written ☐ suit filed
10. Date suit filed, if any was initiated: _____

B. This form was completed by: _____

Date: _____ Phone Number: _____

Email Address: _____

C. Mail completed form to:
   1. The appropriate State of Kansas health care provider regulatory agency, and
   2. Kansas Health Care Stabilization Fund
      300 SW 8th Avenue, 2nd Floor
      Topeka, KS 66603-3912

*** Failure to report the information requested on this form may result in a civil fine of $1,000.00 per day. [K.S.A. 40-3421(d)]**