RESET

SETTLEMENT NOTIFICATION

State Form 9900411 (4-26)
INDIANA DEPARTMENT OF INSURANCE

INDIANA DEPARTMENT OF INSURANCE
PATIENT'S COMPENSATION FUND
311 W. Washington St, Ste 103
Indianapolis, IN 46204
Telephone: (317) 941-4248
E-mail: PCFclaims@idoi.IN.gov
Website: in.gov/idoi/medical-malpractice

INSTRUCTIONS:

1. *Complete the form in accordance with IC 34-18-9-3(b), which requires a health care provider's insurer or risk manager to report to the department all claims settled or adjudicated to final judgment against the health care provider.*
2. *Complete the form. Attach additional pages if necessary.*
3. *Mail or email the completed form to the Patient's Compensation Fund using the contact information provided on this form.*

PCF Claim Number (If Known)	
Plaintiff's Name	
Damages Asserted and Alleged Injury	
Nature of Claim *(select one)*	
If other, please describe:	

Insured	Settlement or Judgment Amount	Settlement or Judgment Date	Legal Fee	Legal Expense	Settlement or Judgment *(select one)*