



RESERVE NOTIFICATION

State Form 9900421 (04-26)

INDIANA DEPARTMENT OF INSURANCE

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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(a), which states that the health care provider's insurer shall notify the Insurance Commissioner of any malpractice case upon which the insurer has placed a reserve of at least \$125,000.
2. Mail or email the completed form to Patient's Compensation Fund using the contact information provided on this form.

PCF Claim Number (If Known)	Plaintiff's Name	Insurance Carrier	Carrier Claim Number	Policy Number	Date of Loss	Insured	Reserve Amount