NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Division of Public Health
Investigations - Healthcare Professionals and Occupations

Mandatory Report of Insurers Reporting Licensed Health Professionals

Insurers reporting Licensed Health Professionals for adverse judgment or settlement as a result of a suit, claim, or violation of insurance coverage, to the Division of Public Health - Investigations Unit.

State of Nebraska
Department of Health and Human Services, Division of Public Health
Office of Professional & Occupational Investigations
P.O. Box 94722, Lincoln, Nebraska 68509
Phone: 402-471-0175
Fax: 402-742-8335
Email: DHHS.InvestigationsPOL@nebraska.gov

Identifying Information for Professional I am Reporting:

Prefix	First Name	Last Name	Middle Initial	Suffix

Primary Phone	Alt Phone	Fax

Email Address

Physical Address:

Address Line 1	Address Line 2

City	State	Zip Code

Is Mailing Address the same as Physical Address? ☐ Yes ☐ No

Mailing Address:

Address Line 1	Address Line 2

PO Box	City	State	Zip Code

List the profession and license number for each Nebraska license, certificate, or registration held:

Profession	License Number

Reporting Party Information

Business Name*			
Contact/Owner Prefix	Contact/Owner First Name*	Contact/Owner Last Name*	Contact/Owner Suffix
Primary Phone	Alt Phone	Fax	
Email Address			

Physical Address

Address Line 1	Address Line 2	
City	State	Zip Code

Is Mailing Address the same as Physical Address? ☐ Yes ☐ No

Mailing Address

Address Line 1		Address Line 2	
PO Box	City	State	Zip Code
Relationship to Health Care Professional			
Preferred Method of Contact			

Do you wish to remain anonymous? ☐ Yes ☐ No

☐ 1. We have made a payment resulting from a professional liability claim.

☐ 2. We have taken an adverse action that affects the coverage provided by the insurer due to alleged:
- ☐ Incompetence
- ☐ Negligence
- ☐ Unethical or unprofessional conduct
- ☐ Physical, mental or chemical impairment
- ☐ Other_____

Type of action taken
- ☐ Denial of coverage
- ☐ Refusal to renew coverage
- ☐ Coverage terminated or cancelled
- ☐ Coverage limited, reduced or modified
- ☐ Premium or rate increase
- ☐ Other_____

Date adverse action was taken:_____

Please select one.*
- ☐ Person is subject to National Practitioner Data Bank requirements and Data Bank Supplement form completed.
- ☐ Person not subject to National Practitioner Data Bank and next page completed.

☐ 3. The insurer has reasonable grounds to believe that the practitioner has committed a violation of the regulatory provisions governing the profession or practitioner.

☐ 4. The Department has requested the insurer to provide information.

Patient or Client	
Name	
Address	
Location of act, omission, or conduct being reported	
Name:	
Address:	
Date of Occurrence	
Malpractice Payment	
Name of Patient or Client	
Address	
Name of Court	
Address	
Date of Judgment, Settlement, or Award	Date of Payment
Amount of Payment	
List all persons present at time of incident that would have first-hand knowledge of the incident	
Name	
Title	Phone
Address	
Name	
Title	Phone
Address	
Name	
Title	Phone
Address	

Reason for Complaint*

Please describe the complaint and include as much detail as possible. Attach any additional documentation.

The statements I have made are true and correct to the best of my knowledge.

Please sign your name below.*

Date Signed*