AGGREGATE EROSION REPORTING FORM (AEF-1)

(Updated June 2015)

Insured Information	
Health Care Provider Name and Current Address	PA License Number
Insurer and Policy Information	
Name of Insurer	Policy Number
Policy Type:	Policy Limits:
Policy Coverage Dates: __/__/____ to __/__/____	
Paid Claim Information	
Full Case Caption (including venue and docket #)	Mcare File # (if any)
Date of Occurrence: __/__/____	Date Claim Reported: __/__/____
Brief Factual Summary	
Date of Settlement/Judgment __/__/____	
Date of Claim Payment: __/__/____	Amount of Claim Payment: $
Contact Person Information	
Contact Person:	Telephone Number (with ext.):
Email address:	Date Form Completed: __/__/____

Bureau of Medical Care Availability and Reduction of Error Fund (Mcare) Claims
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