pennsylvania
INSURANCE DEPARTMENT

C-416 CLAIM REPORTING GUIDELINES

(Updated May 2015)

The Form C-416 Claim Report ("C-416") is submitted by the basic coverage insurance carrier or the self-insured provider ("insurer") in order to properly place the Medical Care Availability and Reduction of Error Fund ("Mcare") on notice of a claim against a Mcare participating Health Care Provider ("HCP"). These instructions are intended to provide insurers with guidance in completing the C-416. Please feel free to contact Mcare Claims using the contact information below regarding any questions.

Please remember to:

- Include preparer name, phone number, email and signature.
- Complete all items.
- Include all attachments.
- Continue to provide information.

COMPLETING THE C-416

Below are explanations of what information should be included on a properly completed C-416:

1a. Insurer Name and Address – Enter full name and address of insurer.

Third Party Administrators – If a third-party claims administrator is completing the form and administering the claim, its name and address is to be provided in block 1a. under the name of the insurer of record.

Novation and/or Assumption Agreements – If insurer has coverage for this claim as a result of a novation and/or assumption agreement, enter the current name followed by the former name.

1b. Insurer Claim / Policy Information – File number, policy number, policy type, policy dates, policy limits.

Policy Type Acronyms:

CM - Claims Made	RE – Retroactive
OC – Occurrence	TA – Tail
OP – Occurrence Plus	PA – Prior Acts

If a novation exists, provide the current insurer's policy number followed by the policy number of the insurer whose coverage was assumed and enter the word "novation" after the last policy number.

2a. Health Care Provider Full Name, Employer Name & Address

2b. Health Care Provider Information – Date of birth, PA license number, professional school attended, and year of graduation.

3a. Claimant/Injured Person Full Name & Address

3b. Claimant/Injured Person Information – Date of birth, age at time of incident, gender, occupation, Social Security number.

4a. Starting Date of Alleged Malpractice and Ending Date of Alleged Malpractice – Provide month, day and year(s).

Choose one - Excess, Section 715 or Drop Down.

Excess – This is a claim where the insurer is notifying Mcare in order to have access to excess coverage as provided for under the Mcare Act. Excess claims should be reported to Mcare promptly.

Section 715 – This is a claim where the insurer is requesting, on behalf of its insured HCP, defense and first dollar indemnity from Mcare. Section 715 coverage has the following requirements in addition to those ordinarily required for Mcare coverage:

- the last date of criticized treatment is more than four years before notice of the claim was given to the health care provider or their insurer, and
- at least one of the criticized treatment dates is on or before December 31, 2005 (note that Mcare will consider claims for Section 715 coverage if the dates of criticized treatment are both before and after December 31, 2005), and
- the claim was filed within the applicable statute of limitations, and
- Mcare has received the C-416 within 180 days of the date on which notice of the claim is first given to the health care provider or the insurer, whichever is earlier.

(If there is a question as to whether the claim may qualify for Section 715 coverage, the insurer should still submit a C-416 with supporting documentation requesting Section 715 coverage to Mcare in order to meet the 180 day requirement.)

Drop down – This is a claim where the insurer's primary insurance aggregate limits for the insured have been exhausted by indemnity payments made on behalf of the insured.

4b. Reported Dates of Malpractice – Date claim first reported to insured, date first reported to insurer, date of serious event notification to claimant (if any), and the date of suit or demand for damages, whichever date is earlier.

The Mcare Act requires a medical facility to provide "written notification to a patient affected by a serious event or, with the consent of the patient, to an available family member or designee, within seven days of the occurrence or discovery of a serious event."

5. **Place Alleged Injury Occurred** – Name of office or facility, street address, city, county and state where the alleged injury occurred.

6a. **Severity of Alleged Injury** – Definitions of severity codes follows the C-416 instructions (see Attachment A for additional details). The codes track National Practitioner Data Bank definitions.

0 – Unknown
1 – Emotional Injury Only
2 – Insignificant Injury
3 – Minor Temporary Injury
4 – Major Temporary Injury
5 – Minor Permanent Injury
6 – Significant Permanent Injury
7 – Major Permanent Injury
8 – Grave Permanent Injury
9 – Death

6b. **ICD-9/10** – Provide known codes, if available (ICD-10 effective for dates of injury on or after 10-1-2015).

6c. **Nature of Treatment Giving Rise to Claim** – Describe principal injury alleged.

7. **Claimant/Injured Person's Present Condition and Prognosis**

8. **Additional Defendants /Additional Defendants' Insurers**

9. **Plaintiff Attorney Name, Address, Phone number**

10. **Defense Attorney Name, Address, Phone number**

11. **Insurer Claim Reserve**

12. **Preparer Name, Email Address, Title, Phone number, Signature and Date** – A written or electronic signature of the insurer representative is acceptable. By signing the form the preparer attests to their authorization by the insurer in block 1a. to submit the claim report.

ATTACHMENTS to C-416

The following materials are to be submitted with the C-416:

- The writ of summons, legal complaint, demand for damages, and/or details concerning the claim
- All communications received from plaintiff's counsel and relevant materials from defense counsel
- Pertinent discovery materials or summaries thereof in the possession of the insurer
- All applicable orders issued by the court in the possession of the insurer

SUBMITTING the C-416

All methods of submission require the C-416 to be dated and signed and contain the attachments listed above. Mcare offers the following ways to submit the C-416: email, fax or mail.

Email
Emailed forms must be either signed and scanned or electronically signed before submission. Emailed forms should be in .pdf format and sent to ra-in-mc-c416claim@pa.gov with a subject line of "claimant last name, first name and HCP last name, first name – C416."

PLEASE NOTE: Multiple HCP's are to be submitted on separate C-416's for the same claimant but may be contained within the same email if file size permits. Generally it is preferable that attachments are sent within the same email as the submission of the C-416. However, if attachments are too large, the same subject line should be used on associated emails that contain attachments. (The Commonwealth's current email size restriction is 10 MB).

Fax
Completed C-416's may be faxed to 717-787-0651. The cover sheet should contain the claimant's last name, first name and HCP last name, first name – C-416.

Mail
Completed C-416's may be sent U.S. Mail to P.O. Box 12030, Harrisburg, PA 17102. Other mail services such as Fed Ex, UPS, etc. should use the Mcare street address.

REVIEW OF AND ACTION ON C-416

Mcare will review the C-416 and decide whether to accept or reject it. If accepted, Mcare will notify the insurer in block 1a.

If the C-416 is rejected because it is incorrectly filled out or information is incomplete, Mcare will communicate with the entity in block 1a. by email, unless an email address has not been provided. Corrected C-416 forms should be resubmitted in accordance with these guidelines.

ONGOING ADDITIONAL RESPONSIBILITIES

Please continue to provide the information on Attachment B.

ATTACHMENT A

INJURY SEVERITY CODE DEFINITIONS

(FROM THE NATIONAL PRACTITIONER DATA BANK)

CODE	Definition
0	Unknown
1	Emotional Injury (upset, fright) Shock to nerves or nervous system with no physical injury alleged.
2	Insignificant Injury (small cuts, lacerations, contusions, minor scars, rash, etc.) Physical injury involving minor treatment or no treatment.
3	Minor Temporary Injury (infections, fractures, minor burns, missed or delayed diagnosis and/or recovery without complications) Physical injury is minor, but treatment continued before recovery occurred.
4	Major Temporary Injury (retained foreign object, other burns, side effects from medication or treatment, brain damage that resolves, infection after surgery, etc.) Temporary injuries of a significant nature. Complications that result in a longer treatment regimen, but no residual injuries exist.
5	Minor Permanent Injury (loss of fingers, loss or damage to organs, heart damage with recovery, removal of bowel, loss of one testicle or ovary, etc.) Permanent injuries, which have no long-term effects on activities of daily living.
6	Significant Permanent Injury (deafness, complete or partial loss of limb, eye, one kidney or lung, brachial plexus injury, reflex sympathetic dystrophy which is disabling, etc.) Permanent injuries with long-term effects on activities of daily living.
7	Major Permanent Injury (paraplegia, blindness, loss of two limbs, brain damage, severe and visible disfigurement, permanent colostomy, aseptic necrosis of a joint, a central nervous system injury which is not totally disabling, etc.) Injury is severe or is an amplification of a significant permanent injury. Brain damage for which there are permanent residual effects.
8	Grave Permanent Injury (quadriplegia or severe brain damage requiring lifelong care, persistent coma, etc.) Most serious of injuries where all aspects of life are significantly compromised, but death has not occurred.
9	Death Allegations are that death occurred due to the actions of the health care provider.

ATTACHMENT B

After receipt of the Mcare C-416 acknowledgment letter, the insurer should report to Mcare the following information within 30 days of their receipt:

A. Copy of writ of summons, complaint, and any amended complaint(s) and responses.

B. All special damages alleged including past and/or future economic loss, medical special damages, and related expert reports.

C. Copy of any scheduling orders issued by the court.

D. Relevant medical records, including hospital admission, operative, and discharge summaries; physician office and laboratory reports.

E. Copies of all medical expert reports of plaintiff and defendant(s).

F. Defense counsel summaries of pertinent discovery answers and depositions.

G. Copies of correspondence from the insurer or their representatives seeking consent to settle and responses.

H. Copies of all demand letters.

I. Significant correspondence received from defense counsel including periodic claim status/evaluation and pretrial reports.

J. Case development communications and evaluations prepared by the insurer.

K. Pretrial statements to the court prepared by plaintiff and defense counsel.

L. Copies of stipulations dismissing any parties.

M. Scheduled dates of trial and any settlement, pretrial or other conferences.

N. Any other information that is pertinent to the analysis and evaluation of the claim.