

## CAQH Disclosure/Malpractice Question Narrative

Practitioner Name:				
	(Last)	(First)	(Middle Initial)	(Degree)
If you have answered affir page for each incident (ad		losure or malpractice questio if necessary).	ons on the CAQH application	, complete this
Complete <b>Section 1</b> for res (CAQH Disclosure Questio		to disclosure questions <i>other</i> )	than malpractice claims.	
	•	(CAQH Disclosure Question # ars; Recredentialing - report o		
Complete a separate form	for each incident.	Add additional pages if applic	able.	
1. DISCLOSURE Narrativ	e for CAQH questi	ion #(enter applicable no	umber(s)	
Describe, in your own wor	r <b>ds</b> , the circumstanc ter from the attorne	es and course of events surro ey or the malpractice carrier o	ounding the issue, including	the outcome
I certify that the	information in this (	document is correct and com	plete to the best of my kno	wledge.
Practitioner Signature			Date	

## 2. MALPRACTICE CLAIM Narrative for CAQH question # 19

A letter from the attorney or the malpractice carrier does not replace this form. Patient's Initials: Date of Incident: \_\_\_\_\_ Date of Claim or Suit Filed: Location of Incident: Claim Status: 

Dropped from case (No further information needed – Proceed to signature line below) ☐ Dismissed without Prejudice ☐ Dismissed with Prejudice  $\square$  Settled with Prejudice ☐ Settled without Prejudice ☐ Judgment for Plaintiff ☐ Judgment for Defendant ☐ Closed Date Closed: ☐ Notice of Intent/Pre-Suit/180-day Letter Your Status: ☐ Primary Defendant ☐ Co-Defendant ☐ Other (specify): \_\_\_\_\_ Your Role in the case: ☐ Admitting/Attending Physician ☐ Surgeon ☐ Consultant ☐ Resident ☐ Other: Amount paid on your behalf, if any: \$\_\_\_\_\_\_ Date of Payment: \_\_\_\_\_ Describe, in your own words, the circumstances and course of events surrounding the issue, including the treatment or procedure you provided and the outcome of the patient's condition. Attach another sheet if more space is needed. I certify that the information in this document is correct and complete to the best of my knowledge. Practitioner Signature Date