Reporting Form For Claims Relating To The Virginia Birth-Related Neurological Injury Compensation Program*

Company Information:

Company Name: _____

Address: _____

_____

Contact Name: _____

Phone: _____ Email: _____

Insured's Information *(physician or hospital)**:***

Insured's Name: _____

Address: _____

Phone: _____

If the insured is a physician, please give delivering hospital's name, or if insured is a hospital, please give delivering physician's name:

_____

Claimant Information:

Claimant's Name (child): _____

Claimant's Parents/Guardians: _____

Address: _____

Phone: _____

Date notice of claim received: _____

This form completed by: _____

Signature: _____

Please mail or fax this form (with receipt confirmation via mail or phone) to:

Virginia Birth-Related Neurological Injury Compensation Program
7501 Boulders View Drive, Suite 210, Richmond, VA 23225
804-330-2471 Fax: 804-330-3054

***This form is required by the Code of Virginia as noted in 38.4–5004.1 Submitting this form is not a petition to admit a child into the Birth-Injury Program. Admission into the Program is obtained solely through the Virginia Worker's Compensation Commission.**