

Subpoena Notification

Scan and email the completed form to: claims@cphins.com OR
Fax to: 312-987-0902 (please call 5 minutes after faxing to confirm receipt). OR
Overnight mail to: CPH & Associates, 711 S. Dearborn, Suite 205, Chicago, IL 60605

**You must answer ALL questions on this form. If something does not apply to you, write "N/A" on that line.
Attach additional information as necessary.**

Name:	Expiration date of Current Policy:
Policy Number(s):	Date First Insured with CPH & Associates:
Phone:	Email Address:

- 1.) **Prior Carriers and effective dates of coverage with each:**
- 2.) **Date Subpoena was received:**
- 3.) **Location of Subpoena (State):**
- 4.) **Dates of Treatment/Evaluation of Involved Client(s)*:**
**Be as accurate as possible with dates of treatment.*

✓ *If you were not insured with CPH and Associates at the time the claim was made against you or discovered, please contact the insurance carrier with whom you were insured at that time.*

*****Please forward a copy of the subpoena received along with this report. Treatment notes, records and other patient Private Health Information are not necessary at this time. *****

PLEASE READ AGREEMENT AND CHECK ONE ANSWER:

The insured declares the information contained in the incident report is true and that no material facts have been suppressed or misstated.

I Agree **I Do Not Agree**

Signature: _____ **Today's Date:** _____