Medical Practice Total Loss Inventory List

Practice Name: _____ Date of Incident: _____ Claim Reference Number: _____

General Information

Name of Medical Professional/Practice: _____

Address: _____

Phone Number: _____ Email: _____

Insurance Information

Insurance Company: _____

Policy Number: _____

Claim Adjuster's Name (if known): _____

Claim Adjuster's Contact Information: _____

Item Description	Quantity	Model Number	Serial Number	Original Cost ($)	Estimated Current Value ($)	Condition Before Loss	Supporting Documents (Attach Receipts/Invoices, Photos, etc.)

Item Description	Quantity	Model Number	Serial Number	Original Cost ($)	Estimated Current Value ($)	Condition Before Loss	Supporting Documents (Attach Receipts/Invoices, Photos, etc.)

Replacement Plan
Replacement Priority

Timeline for Replacement

Signatures

I, the undersigned, confirm the accuracy of the information provided in this Total Loss Inventory List.

Signature:
Date: