Physicians Regulatory Insurance Program Application

Agency Contact
Address
City State Zip Code
Business Phone Fax E-mail Address

The insurance for which you are applying is a claims-made and reported form of coverage. Only claims first made and reported to the Underwriters on or after the effective date but before the end of the Policy Period, or any applicable extended reporting period, will be covered, subject to any retroactive date.

This Application will give the Underwriters an understanding of your billing practices. The completion of this application does not bind coverage. **All questions must be answered completely**. If a question is not applicable, answer by stating "Not Applicable" or "NA". If the answer to a question is none, answer by indicating "None" or "O". If more space is needed to answer a question, attach a separate piece of paper and identify the question to which it pertains. **The Physician/Practitioner Warranty Statement (Section V) must be completed and signed by an officer of the practice.**

I. GENERAL INFORMATION

Applicant's Name (If entity please state)
Address
City State Zip Code
Business Phone Fax

Requested Effective Date	Requested Retroactive Period ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years

Name of entity as it is to appear on policy documents

Type of entity (i.e. P.A., P.C., LLP, Partnership)

Specialties of practice:

Named entity coverage is available only when all practitioners (employed or contracted) apply.

Please provide the following census information, including all practitioners whether employed or contracted:

Number of Practitioners in Group	Number of Physicians working more than 20 hours per week	Number of Physicians working 20 hours or less per week	Number of Nurse Practitioners/Midwives/ CRNAs	Number of RNs, LPNs and Physician Assistants

II. PAYOR INFORMATION

Please provide the following information regarding the "Payor Mix" of your practice:

Payor Source	Gross Billings for the past 12 months	Collections for the past 12 months
Medicare	$	$
Medicaid	$	$
Medicare Founded HMO	$	$
All Other (Commercial, Cash, etc.)	$	$
Total	$	$

Total for all Payors should equal gross billings and collections for the entire practice

III. BILLING PROCEDURES

Question	Answer
Does your practice have a billing compliance program? If answering "no", please describe your billing guidelines on a separate piece of paper	☐ YES ☐ NO
Does your practice have a written policy regarding collection of receivables balances?	☐ YES ☐ NO
If answering "yes", does the policy include write-offs of outstanding balances, co-payments and deductibles?	☐ YES ☐ NO
Is your practice using a current edition of the CPT manual?	☐ YES ☐ NO
Does your practice keep EOB files after they are recorded in the billing system?	☐ YES ☐ NO
Does your practice keep a separate file of outstanding/denied/questioned EOBs?	☐ YES ☐ NO
Are all contracts and referral relationships reviewed by outside counsel to ensure they conform with anti-kickback statutes?	☐ YES ☐ NO
Are billing and procedure codes monitored to alert practice management of possible upcoding, over-utilization or other billing anomalies?	☐ YES ☐ NO
Does your Practice monitor free and / or discounted samples of medications and supplies to guard against co-mingling with purchased inventory or inappropriate billing for items dispensed?	☐ YES ☐ NO
Does the entity/ physician transmit any protected health information electronically?	☐ YES ☐ NO
If yes, does the entity comply with HIPAA's Privacy Rule for Covered entities?	☐ YES ☐ NO
Is any physician required (by medical staff documents at any hospital's emergency department) to serve "on-call" for patients requiring emergency treatment?	☐ YES ☐ NO
If yes, is the physician familiar with their responsibilities under EMTALA as they apply to individual physicians?	☐ YES ☐ NO

If answering "yes" to any of the following questions, please describe in detail, on a separate sheet of paper, each incident.	
Have you or anyone within the entity ever been reviewed by the State Board of Medical Examiners?	☐ YES ☐ NO
Have you or anyone within the entity ever lost any medical practice privileges, other than voluntary termination, with any provider?	☐ YES ☐ NO
Have you or anyone within the entity ever been investigated or sanctioned by any local, state or federal government or agency regarding the delivery of health care services or reimbursement thereof?	☐ YES ☐ NO
Have you or anyone within the entity ever been involved in a stark / anti-kickback investigation?	☐ YES ☐ NO
Have you or anyone within the entity ever been sued or deselected from a commercial payor?	☐ YES ☐ NO

If billing is currently performed by a third party billing company please provide the following information:		
Billing Company's Name		
Address		
City	State	Zip Code
Please describe any common ownership that exists between the Applicant's practice and the third party billing company.		
Does the third party billing company have a compliance program?		☐ YES ☐ NO

If billing is currently performed in-house please provide the following information:

Number of individuals responsible for billing	* Number of credential billers

* A Credential Biller is one who has completed certification course relative to billing and coding procedures.

IV. DATA SECURITY

Is all personally identifiable and confidential information that is transmitted by you, stored on your systems or removed from your premises in any electronic form encrypted? If no, please provide brief details of what measures are in force to protect such information:	☐ YES ☐ NO
Do you have regularly updated antivirus software and firewalls in place within your networks and undertake off site data back ups on at least a monthly basis? If no, please provide brief details of what measures are in force to protect your network and data:	☐ YES ☐ NO

V. PROFESSIONAL CENSUS

Please provide a complete list of all professional staff and their designation below. This page may be duplicated as necessary. Signatures are not required in this section. Please type or print legibly.

	Name	Designation	Full Time	Part Time
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

VI. PHYSICIAN/PRACTITIONER WARRANTY (To be completed and signed by an officer of the entity)

An officer of the practice must read the following statement:

The Undersigned warrants and represents that, to the best of his/her knowledge, the statements herein are true, and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. It is represented that the particulars and statements contained in the Application, and any materials submitted (which shall be on file with the Underwriters and shall be deemed attached, as if physically attached) are the basis for the proposed insurance and are to be considered incorporated into and constituting a part of the proposed insurance.

The Undersigned agrees that in the event this Application contains misrepresentations or fails to state facts materially affecting the risk assumed by the Underwriters, any insurance issued shall be void in its entirety.

The Undersigned agrees that, if after the date of this Application and prior to issuance of any insurance, any occurrence, event or other circumstance should render any of the information contained in this Application inaccurate or incomplete, the Undersigned shall notify the Underwriters of such occurrence, event or circumstance, and shall provide the Under writers with information that would complete, update or correct the information contained in this Application. Any outstanding quotations may be modified or withdrawn at the sole discretion of the Underwriters.

The Underwriters are hereby authorized to make an investigation and inquiry in connection with this application as it may deem necessary.

The Undersigned warrants that they are duly authorized by the by laws of the group or entity to execute this warranty on behalf of the group or entity, and confirms that they have made the necessary inquiries to assure underwriters of the accuracy of the statements made hereon.

An officer of the practice must answer the following two statements, sign and date below. If you cannot agree to either of the following two statements, please attach a detailed explanation.

Statement 1. I agree with the above physician/practitioner warranty.

Statement 2. I have no knowledge of any specific claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the proposed policy.

PLEASE BE SURE TO RESPOND TO BOTH STATEMENTS WHERE INDICATED AND SIGN AND DATE WHERE INDICATED, UNDATED SIGNATURES CANNOT BE ACCEPTED.

Applicant's Name (Please type or print legibly)	Signature / Title	Date	Response to Statement 1	Response to Statement 2
			☐ AGREE ☐ DISAGREE	☐ AGREE ☐ DISAGREE