NAS Insurance Services, inc.

Application for MEDEFENSE PLUS
Billing Errors & Omissions Insurance (Claims Made and Reported) — For Individual Physicians

The insurer agrees to use all information provided in this Application solely in connection with the proposed insurance.

This insurance does not apply to billing errors for medical services or items which are not provided or prescribed by you.

If a material change occurs to any of the answers given below prior to the inception of any insurance, the Applicant must notify the insurer, and at the sole discretion of the insurer any outstanding quotations may be modified or withdrawn.

The particulars, representations and statements contained in this Application and any other information submitted are the basis for the proposed insurance and will be considered as incorporated into and constituting part of the proposed certificate and/or policy.

This Application must be completed in type or ink by the Applicant. All questions must be answered for a quotation to be given. If more space is needed, please continue your answers on a separate sheet and attach it to this form.

The completion and signing of this Application does not bind the Applicant or the insurer to a policy or certificate of insurance.

I. General Information

1. Name of Physician Applicant: _____

   Address: _____
   (Number) (Street)

   _____
   (City) (State) (Zip Code)

   Telephone Number: ( ) _____ Fax Number: ( ) _____

2. a. Do you have a group affiliation? ☐ Yes ☐ No
   If Yes, please describe: _____

   b. How many physicians are on your staff or in your group? _____
   What is/are your specialty/specialties? _____

   _____

3. Have you acquired any practices in the last 5 years? ☐ Yes ☐ No
   If Yes, please specify details, including size, dates, specialty/specialties involved and what the Medicare/Medicaid billings were as a percentage of the total practice for each acquired practice for each of the past five years.
   (Use separate sheet if necessary.) _____

   _____

   _____

   _____

II. Billing Services and Compliance Plan

1. Do you handle billing in-house? ☐ Yes ☐ No
   a. If No, please list all entities and/or persons who perform billing services for you, and indicate approximately what percentage of your total billings is attributable to each entity and/or person providing said services. The percentages should total 100%.
   Biller ***Percentage***

   _____

   _____

   _____

   _____

   b. If Yes, which compliance/audit software system do you utilize? _____

   _____

   When was it installed? _____

2. a. Your total projected, prospective annual billings: _____
   b. Your percentage of projected, prospective annual billings attributable to Medicare Patients: _____
   c. Your percentage of projected, prospective annual billings attributable to Medicaid Patients: _____

3. Do you have a Compliance Program in place? ☐ Yes ☐ No
   a. If Yes, when was it implemented? _____ **Please provide a copy.**
   b. If No, please explain why. _____
   Are you willing to implement one? ☐ Yes ☐ No
   If Yes, within what time frame: _____

III. Experience

Have you or any member of your staff ever:

1. Been investigated or sanctioned by any local, state or federal government or other agency regarding the delivery of a health care service and/or reimbursement ? ☐ Yes ☐ No

2. Had to refund amounts to Public and/or Private payers? ☐ Yes ☐ No
   If Yes, how much? Public: $ _____ Private: $ _____

3. Have you ever been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? ☐ Yes ☐ No

4. Have you ever been accused of errors by a government agency or commercial payer? ☐ Yes ☐ No

5. Do you have knowledge of any claims or facts, circumstances, situations, events or transactions that may result in a claim which may by covered by the proposed policy? ☐ Yes ☐ No

If answer to any of above responses is "Yes," please explain on a separate sheet of paper.

The undersigned warrants and represents that, to the best of his or 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 insurer 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 Insurer, 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 insurer immediately of such occurrence, event or circumstance and shall provide the insurer 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 insurer.

The insurer is hereby authorized to make an investigation and inquiry in connection with this Application as it may deem necessary.

APPLICANT		
BY (*Owner or Corporate Officer Signature*)	**TITLE**	**DATE**

Serviced By:

NAS Insurance Services, inc.

Lloyd's Correspondent

02/02

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