



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

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must notify the insurer, and at the sole discretion of the insurer any outstanding quotations may be modified or withdrawn.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 Medical Group: _____

Address: _____
(Number) (Street)
(City) (State) (Zip Code)

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

2. Type of entity: [] Incorporated [] LLC [] Partnership [] Joint Venture
[] Sole Proprietorship [] Other

3. If the entity cited above is a partnership, who is the General Partner? _____

4. Date of the formation of the entity cited above: _____

5. Other operational locations and their descriptions (use separate sheet if necessary):

6. 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.)

7. How many physicians make up your group? _____
 What are their specialty/specialties? **(Use separate sheet if necessary.)** _____
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8. Please attach a listing of Medical Malpractice Insurers and policy limits of all physicians in your group.
9. Do you have independent, audited financials? Yes No
Please attach a copy of your financial statements, whether audited or unaudited.
10. If you are incorporated or an LLC, do you have Directors & Officers Liability insurance; or if you are a partnership, do you have Partnership Errors & Omissions insurance? Yes No
11. Do you purchase Managed Care Errors & Omissions insurance? Yes No

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%.
- | <u>Biller</u> | <u>Percentage</u> |
|----------------------|--------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
- 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: _____
- d. What have Medicare/Medicaid billings been for each of the past three years?
- | <u>Year</u> | <u>Billing</u> | |
|--------------------|-----------------------|--|
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |
3. Do you handle billings for any hospitals or provider services not provided by your medical group? Yes No
If "Yes," please describe these services on a separate sheet.

4. 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? _____
5. Is there a Board policy on compliance? Yes No
If "Yes," please provide a copy.
6. Do you have a compliance officer/manager? Yes No
 a. If Yes, who is it, how are they qualified, and to whom do they report?

 b. If No, who ensures compliance? _____
7. Do you use an outside compliance consultant? Yes No
 If Yes, who? _____
8. Who is your legal counsel for compliance issues? _____
9. Who is your CPA firm for compliance issues? _____
10. How often are bill reviews performed, and by whom? _____

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 be 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 (<i>Owner or Corporate Officer Signature</i>)	TITLE	DATE



Serviced By:

NAS Insurance Services, Inc.

Lloyd's Correspondent