APPLICATION for: **MEDICAL BILLINGS E&O and REGULATORY DEFENSE POLICY**

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

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

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must notify the insurer, and at the sole discretion of the insurer, any outstanding quotations may be modified or withdrawn.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

The Applicant is required to make internal inquiry before completing this Application. 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.

"You" and "your" as used in this Application shall mean the Applicant.

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

SECTION I. GENERAL INFORMATION

1. Name of Applicant: _____

   Principal Address: _____

   City: _____ State: _____ Zip: _____

   Telephone Number: _____ Email Address: _____

   Website: _____

2. Description of Operations: _____

   _____

   a) If a physician/medical group:

      Number of physicians: _____

      Specialty: _____

3. If the Applicant is an entity, date of formation of the entity: _____

4. Please provide a list of subsidiaries and entities owned by the Applicant. Please describe the nature of business of each such subsidiary or entity, its relationship to the Applicant, and the percentage of ownership by the Applicant._

   _____

   _____

5. Applicant's Annual Revenues: Current Year: _____ One Year Ago: _____ Two Years Ago: _____

6. Have you acquired any practices in the last 5 years?..... ☐ Yes ☐ No

   If you answered **"Yes"** to question 6, please provide specific details, including the size of each practice, date(s) of acquisition, the specialty/specialties of each practice, and total percentage of Medicare/Medicaid billings, if any, for each practice for each of the past five years. **(Use separate sheet)**:

   _____

   _____

   _____

7. a) Applicant's total annual projected billings: $_____

   b) Percentage of annual projected billings attributable to Medicare Patients: _____

   c) Percentage of annual projected billings attributable to Medicaid Patients:

   d) What have your Medicare/Medicaid billings been for each of the past three years?

   Current Year: _____ One Year Ago: _____ Two Years Ago: _____

8. Have any officers or senior management voluntarily or involuntarily left your employ within the last 18 months? ☐Yes ☐No

   If you answered "Yes" to question 8, please provide specific details, including the exact date (mm/dd/yyyy) of the separation, the name and title of each individual, and the reason each individual's employment was discontinued. (Please use a separate sheet if necessary):

_____

_____

_____

SECTION II. COMPLIANCE

9. Do you have a billing compliance program in place?..... ☐Yes ☐No

   If you answered "**Yes**" to question 9, when was it implemented?_____

   If you answered "**No**" to question 9, please describe your billing guidelines on a separate sheet of paper.

10. Do you utilize credentialed staff to perform billing procedures? ..... ☐Yes ☐No

    If you answered "Yes" to question 10, how many?_____

11. Is your practice using a current edition of the CPT manual? ..... ☐Yes ☐No

12. Is software used to ensure billing compliance?..... ..... ☐Yes ☐No

    If you answered "Yes" to question 12, when was it installed? _____

13. Who is responsible for billing compliance? Please include their name, title, qualifications and date of hire in this position:

_____

_____

14. If you outsource your billing to a third party billing company, are certified billers used? ..... ☐Yes ☐No

15. How often are billing reviews performed and by whom? _____

16. Are all contracts and referral relationships reviewed by outside counsel to ensure you are compliant with anti-kickback statutes/regulations?..... ☐Yes ☐No

    If you answered "Yes" to question 16, please provide the date of last review? _____

SECTION III. LOSS HISTORY

After internal inquiry, have you or any member of your staff, or any person or entity for whom you perform billing services ever:

17. Been investigated or sanctioned by any local, state or federal government agency or private (commercial) payer regarding the delivery of health care services or reimbursement thereof? ..... ☐Yes ☐No

18. Had to refund amounts to Public and/or Private Payers within the last 3 years? ..... ☐Yes ☐No

    a) If you answered **"Yes"** to question 26, please provide estimated amounts:

    Current Year (Fiscal): Public: $_____ Private: $_____

    Last Year (Fiscal): Public: $_____ Private: $_____

    Two Years Ago (Fiscal): Public: $_____ Private: $_____

b) If you answered **"Yes"** to question 26, were these refunds due to an audit, allegation of improper billing or voluntary self-disclosure? ..... ☐Yes ☐No

19. Been:

a) Audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? ..... ☐Yes ☐No

b) Been placed on prepayment review by any local, state, or federal government agency? ..... ☐Yes ☐No

c) Been placed on prepayment review by any private (commercial payer)? ..... ☐Yes ☐No

20. Been sued or deselected from a private (commercial) payer? ..... ☐Yes ☐No

21. Been reviewed, investigated or sanctioned by a state medical licensing board? ..... ☐Yes ☐No

22. Been involved in a stark/anti-kickback investigation? ..... ☐Yes ☐No

23. Been accused of billing errors by any local, state or federal government agency or private (commercial) payer? ..... ☐Yes ☐No

24. Been investigated for HIPAA or EMTALA violations? ..... ☐Yes ☐No

25. Been non-renewed, placed on extension, or declined for similar coverage? ..... ☐Yes ☐No

26. Experienced any incidents and/or received any complaints or claims or been the subject of litigation involving matters of privacy, injury, identity theft, denial of service attacks, computer virus infections, theft of information, damage to third party networks, or your customer's ability to rely on your network? ..... ☐Yes ☐No

27. Been aware of any facts, circumstances, situations, events or incidents that could result in a regulatory action, regulatory investigation or demand for restitution? ..... ☐Yes ☐No

28. In the last five (5) years, been aware of any security breaches, privacy breaches, privacy-related incidents or allegations of breach of privacy? ..... ☐Yes ☐No

If the answer to any of questions 17 through 28 is "Yes", please explain on a separate sheet of paper.

SECTION IV. OTHER INFORMATION

1. The undersigned declares that the statements herein are true and correct and that reasonable efforts have been made to obtain sufficient information to facilitate the proper and accurate completion of this Application. The signing of this Application does not bind the undersigned to complete the insurance.

2. It is warranted that the particulars and statements contained in this Application and any materials submitted herewith (which shall be retained on file by Underwriters and which shall be deemed attached hereto, as if physically attached hereto) are the basis for the proposed Policy (should a Policy be issued) and will be considered as incorporated into and constituting a part of the proposed Policy (if issued). Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application as they may deem necessary.

3. 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.

4. It is agreed that, if after the date of this Application and prior to issuance of the insurance policy, any information supplied on this Application changes, the undersigned shall immediately notify the insurer of such change(s) and shall provide the insurer with any 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.

5. For purposes of creating a binding contract of insurance by this Application or in determining the rights and obligations under such a contract in any court of law, the parties acknowledge that a signature reproduced by either facsimile or photocopy shall have the same force and effect as an original signature and that the original and any such copies shall be deemed one and the same document.

Severability: No knowledge or information possessed by any insured person will be implied to any other insured person except for material facts or information known to the person or persons who signed the Application. In the event that any of the particulars or statements in the Application are untrue, this policy will be void with respect to any insured person who knew of such untruth or to who such knowledge is implied.

Authorized Signature (Must be signed by the Applicant's President, CEO or COO): _____

Title: _____ Print Name: _____

Applicant Organization: _____ Date (MM/DDIYYYY): _____