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APPLICATION FOR INDEPENDENT AMBULATORY SURGICAL CENTERS GENERAL (OCCURRENCE OR CLAIMS MADE) AND PROFESSIONAL LIABILITY INSURANCE (CLAIMS MADE BASIS)

NOTE: FACILITIES HANDLING EMERGENCY MEDICINE, ELECTIVE COSMETIC SURGERY, ABORTIONS, BARIATRIC SURGERY, OR ARE OWNED BY, OPERATED BY, OR LOCATED IN HOSPITALS ARE NOT ELIGIBLE. PLEASE TYPE OR PRINT IN INK. PLEASE ANSWER ALL QUESTIONS COMPLETELY, USING ADDITIONAL INFORMATION FORM HEREIN IF NECESSARY.

I. GENERAL INFORMATION

1. Full Name of Applicant (include all business, corporate or partnership names): _____

2. Phone: ( ) _____

3. Principal business premise address: _____
(Street)

_____
(City) (County) (State) (Zip)

4. Are all operations provided out of the main location? ☐ Yes ☐ No

If no, please list all locations including a description of services conducted at each location:

Loc. #	Business Name/Address	Total Sq. Ft. Occupied	Description	Year Established	Date Acquired	Ownership %

5. List licenses held by Applicant including type and expiration date: _____

6. Applicant is (check all that apply):
☐ Professional Corporation (For Profit) ☐ Partnership
☐ Professional Corporation (Non Profit) ☐ Other (describe): _____
Please provide separate list of ownership breakdown of the center.

7. Does Applicant own or operate any business other than that shown in Question I.1. above? ☐ Yes ☐ No

8. Number of years this center has been: Operating: _____ Owned by present owners: _____
Managed by present management: _____ Name of management company: _____

9. May any qualified physician apply for privileges at this center? ☐ Yes ☐ No

10. Is Applicant accredited by or a member of any professional organization or association? ☐ Yes ☐ No
If yes, please name: _____

11. Is Applicant certified for Medicare reimbursement? ☐ Yes ☐ No

12. Please describe any acquired or sold entities in the past five years: _____

13. In the past 24 months, has Applicant completed a merger, acquisition, or consolidation with another entity? ☐ Yes ☐ No

If yes, please explain: _____

14. Are there any mergers, acquisitions, or consolidations contemplated in the next 12 months? ☐ Yes ☐ No

If yes, please explain: _____

15. Does Applicant plan to add any new procedures, products or services in the upcoming year? ☐ Yes ☐ No

If yes, please explain: _____

_____

16. Estimated Gross Revenue (next 12 months): _____

17. Requested Coverage: Effective Date: _____

Professional Liability (Claims Made Only)

Limit: $_____ Per claim Retroactive Date: _____

$_____ Aggregate Deductible: ☐ $10,000 ☐ $25,000 ☐ $50,000

Other: _____

General Liability

Limit: $_____ Per claim Retroactive Date: _____ ☐ Occurrence ☐ Claims Made

$_____ Aggregate Deductible: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

Other: _____

II. OPERATIONS

1. Please list all partners or members of the firm who provide professional services: _____

_____

2. Please provide name of medical director and professional specialty: _____

_____

3. In what states is Applicant registered and licensed to practice? _____

_____

If none, please attach explanation.

4. What is Applicant's professional specialty? _____

5. Hours of operation: _____

6. Does Applicant have qualified physician(s) and other personnel trained in emergency medical care in center during all hours of operation? ☐ Yes ☐ No

If yes, please describe: _____

_____

7. Does Applicant maintain any beds for overnight occupancy? ☐ Yes ☐ No

8. Are any services provided for or at Nursing Homes, Assisted Living Facilities or Long Term Care Facilities? ☐ Yes ☐ No

If yes, please describe: _____

_____

9. Does Applicant have the following equipment at the center?

a. Laboratory, with the following capabilities - CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine? ☐ Yes ☐ No

b. X-ray with on-premises processing? ☐ Yes ☐ No

c. EKG -- 12 lead? ☐ Yes ☐ No

d. Monitor/Defibrillator? ☐ Yes ☐ No

e. Crash cart with full cardiac life support capabilities and necessary intravenous fluids? ☐ Yes ☐ No

f. Appropriate trays and equipment for accessing the airway, pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage? ☐ Yes ☐ No

g. Oxygen? ☐ Yes ☐ No

h. Suction? ☐ Yes ☐ No

i. Pneumatic anti-shock trousers? ☐ Yes ☐ No

j. Dedicated telephone lines to the closest appropriate hospital emergency department and/or two-way communication with EMS? ☐ Yes ☐ No

10. Does Applicant treat professional athletes? ☐ Yes ☐ No

11. Anesthesia:

a. Is anesthesia (other than topical or by means of local infiltration) administered by either Applicant or others? ☐ Yes ☐ No

b. If yes, attach detailed explanation and a copy of written policies and/or guidelines of the anesthesia services.

c. If yes, who administers anesthesia? ☐ MD ☐ CRNA ☐ Other (identify): _____

d. If yes, indicate center class definitions by type of anesthesia (check all that apply):

☐ Class A: All surgical procedures are performed in the center under local or topical anesthesia.

☐ Class B: Surgical procedures are performed in the center under local or topical anesthesia and/or intravenous or parenteral sedation, regional anesthesia, analgesia, or dissociative drugs (excluding Propofol) without use of endotracheal or laryngeal mask incubation or inhalation general anesthesia (including nitrous oxide).

☐ Class C: Surgical procedures are performed in the center under local or topical anesthesia and/or intravenous or parenteral sedation, regional anesthesia, analgesia or dissociative drugs, including Propofol, spinal or epidural anesthesia, endotracheal or laryngeal mask incubation or inhalation general anesthesia (including nitrous oxide), administered by an anesthesiologist or certified nurse anesthetist.

12. Are other specialties besides Anesthesiologists privileged to perform Pain Management? ☐ Yes ☐ No

If yes, please provide a list of those other specialties that are privileged.

13. Number of annual X-ray exposures: For diagnosis: _____ For treatment: _____

14. If X-ray treatment is given, what qualifications are required of the staff? _____

_____

15. Are any of the following procedures performed at the center?

a. Bariatrics: ☐ Yes ☐ No

If yes, how many? _____

b. Refractive laser eye surgery: ☐ Yes ☐ No

If yes, what percentage of overall number of procedures? _____

c. Plastic (Cosmetic) Surgery: ☐ Yes ☐ No

If yes, what percentage of overall number of procedures? _____

d. Abortions: ☐ Yes ☐ No

If yes, how many? _____

16. General Liability - Attach separate sheet if needed:

Location	Patient Care Buildings	Other Buildings
Area:		
Age:		
Type of Construction:		
Number of Floors:		
Number of Exits per Floor:		
Are there smoke detectors and fire extinguishers?	☐ Yes ☐ No	☐ Yes ☐ No

Is building completely sprinklered?	☐ Yes ☐ No	☐ Yes ☐ No
Are there fire alarms?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, advise number and type:		
Type of Fire Protection:	☐ City ☐ State	☐ City ☐ State
Fire Department is:	☐ Paid ☐ Volunteer	☐ Paid ☐ Volunteer
Are the electrical, heating and plumbing systems up to code and regularly inspected?	☐ Yes ☐ No	☐ Yes ☐ No

17. Are there elevators on any premises owned, leased or occupied by Applicant? ☐ Yes ☐ No

    If yes, how many? _____

III. CENTER PROCEDURES

1. Is Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No

   If yes:

   a. Has Applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No

   b. Provide the name and title of Applicant's Privacy Officer: _____

2. Does Applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? ☐ Yes ☐ No

   If yes, please attach detailed explanation of this activity.

3. Does Applicant advertise professional services in any manner (other than a simple listing in a telephone directory)? ☐ Yes ☐ No

   If yes, please attach a copy of ALL of the advertisements.

4. Medical Records:

   a. Does Applicant maintain adequate medical records for each patient? ☐ Yes ☐ No

   b. How often and by whom are the medical records reviewed? _____

   c. What arrangements are made for transmitting medical records to other requesting physicians?

5. Are written post-operative orders submitted and signed by the surgeons? ☐ Yes ☐ No
6. Are nursing charts maintained, including patient's condition at time of discharge? ☐ Yes ☐ No
7. Are patients contacted within 24 hours of discharge to determine if there are any complications? ☐ Yes ☐ No
8. How long are orders, consent forms and charts maintained? _____
9. Does Applicant confirm that all practitioners working at the center have current hospital privileges? ☐ Yes ☐ No
10. Please list names/locations of any hospitals or institutions that Applicant uses in practice:
11. Describe in detail Applicant's role/function in the local emergency medical services system:
12. Indicate if employed or contracted healthcare professionals carry professional liability insurance (explain any "no" answers on a separate sheet):

    a. Physicians or surgeons? ☐ Yes ☐ No

    b. Oral surgeons, dentists, nurse anesthetists, nurse practitioners, physician assistants and nurse midwives? ☐ Yes ☐ No

    c. Allied health care professionals? ☐ Yes ☐ No

13. Indicate minimum professional liability insurance limits required for employed or contracted:

    a. Physicians or surgeons: $_____ Each occurrence/$_____ Aggregate

b. Oral surgeons, dentists, nurse anesthetists, nurse practitioners, physician assistants and nurse midwives: $_____ Each occurrence/$_____ Aggregate

c. Allied health care professionals: $_____ Each occurrence/$_____ Aggregate

14. How often does Applicant verify professional liability insurance limits? _____

15. Are providers allowed to post bonds or letters of credit instead of insurance? ☐ Yes ☐ No

If so, how is this verified? _____

16. Do screening/hiring procedures include the following:

a. Educational background? ☐ Yes ☐ No

b. Previous employers/employment history for all employees or physicians? ☐ Yes ☐ No

c. Personal reference checks for all employees or physicians? ☐ Yes ☐ No

d. Hospital privileges for physicians, oral surgeons and dentists? ☐ Yes ☐ No

e. Pending license suspensions or revocations, or any pending disciplinary actions by other facilities? ☐ Yes ☐ No

f. Criminal background check? ☐ County ☐ State ☐ Federal ☐ None ☐ Yes ☐ No

g. Medical professional claims history? ☐ Yes ☐ No

h. Drug/alcohol/abuse screening? ☐ Yes ☐ No

17. Are each of the above procedures followed and documented? ☐ Yes ☐ No

If no, please explain: _____

18. Has the license or certification of any employed/contracted physician or surgeon ever been investigated, limited, revoked, suspended, refused, cancelled or voluntarily surrendered by or to any state or federal licensing board or regulatory agency? This includes but is not limited to Medicare, Medicaid or other reimbursement programs. ☐ Yes ☐ No

a. If yes, please explain: _____

b. If an individual has had a previous claim, license suspension or revocation, how does that impact Applicant's procedures for hiring that person? Are any additional criteria applied?

19. What training is provided for new staff (e.g., aides, volunteers, technicians)? _____

20. Are written job descriptions established for all employees and volunteers? ☐ Yes ☐ No

21. Before staff can provide care, is a competency-based checklist used to assess and document their skills? ☐ Yes ☐ No

22. Does Legal Counsel review all contractual agreements? ☐ Yes ☐ No

23. Hold Harmless and Indemnification Agreements:

a. Has Applicant agreed to hold harmless or indemnify others under contract? ☐ Yes ☐ No

If yes, please attach copy of contract.

b. Does Applicant rent or lease any equipment from others? ☐ Yes ☐ No

If a. or b. is yes, please explain: _____

24. Please describe any services provided to other entities: _____

25. Please describe any contracted services provided to Applicant: _____

IV. APPLICANT STAFF

1. Please describe hiring and verification processes for all employed/independently contracted physicians degrees and experience:

2. Does Applicant have any restricted licensed physicians on staff? ☐ Yes ☐ No

3. Does Applicant have any physicians on staff who do not maintain staff privileges at a hospital? ☐ Yes ☐ No

   If yes, please explain: _____

4. Please describe peer review process for surgeons: _____

5. Does the center require Certificates of Insurance from all staff doctors? ☐ Yes ☐ No

6. Please indicate the number of professional employees, volunteers and independent contractors.
   IF NONE, PLEASE STATE NONE.

	Number of FT/FTE Employees	Number of FT/FTE Volunteers	Number of FT/FTE Independent Contractors
a. Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures:			
b. Physicians: Minor surgery or obstetrical procedures not constituting major surgery:			
c. Proctologists, Ophthalmologists and Urologists:			
d. General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery):			
e. Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery:			
f. Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons:			
g. Physicians' & Surgeons' Assistants, Nurse Practitioners (describe duties on separate sheet):			
h. Interns/residents:			
i. Unlicensed Interns:			
j. Dentists (no oral surgery):			
k. Orthodontists:			
l. Oral Surgeons:			
m. Certified Registered Nurse Anesthetists:			
n. Optometrists, Opticians:			
o. Pharmacists:			
p. Perfusionists:			
q. Podiatrists:			
r. Chiropractors:			
s. RNs, LPNs, LVNs:			
t. X-ray Technician:			
u. Physical therapist/pulmonary therapists:			
v. Other misc. medical personnel (please specify and attach list):			

7. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No

   If no, please explain: _____

8. Does Applicant supervise any individuals other than Applicant's own employees? ☐ Yes ☐ No

   a. If yes, please attach explanation of responsibilities and relationship to the entity which employs these individuals.

b. Please indicate by profession the number of individuals supervised:

Number	Type of Profession	Number	Type of Profession
	Physicians		
	X-ray Technicians		
	Laboratory Technicians		

V. VISITS

1. Provide number of outpatient visits:

Procedure category	Next 12 Months Projected[1]	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior	4th Year Prior	5th Year Prior
All procedures (100%)							
Operations on the nervous system							
Injection of agent into spinal canal							
Release of carpal tunnel							
Operations on the eye							
Operations on eyelids							
Extraction of lens							
Insertion of prosthetic lens (pseudophakos)							
Operations on the ear							
Myringotomy with insertion of tube							
Operations on the nose, mouth, and pharynx							
Turbinectomy/							
Repair and plastic operations on the nose							
Operations on nasal sinuses							
Operations on teeth, gums, and alveoli							
Tonsillectomy with or without adenoidectomy							
Adenoidectomy without tonsillectomy							
Operations on the respiratory system							
Bronchoscopy with or without biopsy							
Operations on the cardiovascular system							
Cardiac catheterization							
Operations on the digestive system							
Esophagoscopy and gastroscopy							
Dilation of esophagus							
Endoscopy of small intestine with or without biopsy							
Endoscopy of large intestine with or without biopsy							
Endoscopic polypectomy of large intestine							
Laparoscopic cholecystectomy							
Repair of inguinal hernia							
Laparoscopy							
Operations on the urinary system							
Cystoscopy with or without biopsy							
Operations on the male genital organs							
Operations on the female genital organs							
Bilateral destruction or occlusion of fallopian tubes							
Hysteroscopy							
Dilation and curettage of uterus							
Operations on the musculoskeletal system							
Partial excision of bone							
Reduction of fracture							
Removal of implanted devices from bone							
Excision and repair of bunion and other toe							

Procedure category	Next 12 Months Projected[1]	Current Year	1st Year Prior	2nd Year Prior	3rd Year Prior	4th Year Prior	5th Year Prior
deformities							
Arthroscopy of knee							
Excision of semilunar cartilage of knee							
Replacement or other repair of knee							
Operations on muscle, tendon, fascia, and bursa							
Operations on the integumentary system							
Biopsy of breast							
Local excision of lesion of breast (lumpectomy)							
Excision or destruction of lesion or tissue of skin and subcutaneous tissue							
Miscellaneous diagnostic and therapeutic procedures							
Arteriography and angiocardiography using contrast material							
Injection or infusion of therapeutic or prophylactic substance							
Operations on the endocrine system or on the hemic and lymphatic system, and obstetrical procedures							

[1] **Visits**: Use a threshold count. Count each patient each time they enter center for healthcare related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department. For home care, count each patient each time Applicant visits for health related services.

VI. APPLICANT HISTORY

1. List prior insurance carried for each of the past five years (separate Primary General Liability and Professional Liability). IF NONE, PLEASE STATE NONE.

Policy Number	Policy Period	Carrier	Limits (GL/PL)		Deductible (GL/PL)	Premium	Claims Made (Y/N)	Retro. Date
			PL					
			GL					
			PL					
			GL					
			PL					
			GL					
			PL					
			GL					
			PL					
			GL					

2. Explain all "Yes" answers using the Additional Information Form herein:

   Has Applicant or any of Applicant's employees:

   a. Ever been the subject of disciplinary or investigatory proceedings or reprimanded by a governmental or an administrative agency, hospital or professional association? ☐ Yes ☐ No

   b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No

   c. Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

   d. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ☐ Yes ☐ No

   e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ☐ Yes ☐ No

VII. CLAIMS HISTORY

1. Has any claim or suit been brought against Applicant and/or any of Applicant's employees? ☐ Yes ☐ No
   a. If yes, please complete a claims supplement for each claim or suit.
   b. Please provide currently valued carrier loss runs.
2. Is Applicant aware of any incident, circumstance or loss which may result in a malpractice claim or suit being made against Applicant or any of Applicant's employees? ☐ Yes ☐ No
   a. If yes, please explain using the Additional Information form herein.
   b. Have they been reported to Applicant's current or previous carrier(s)? ☐ Yes ☐ No
3. Has Applicant ever had any insurance company decline, cancel, rescind or non-renew any Professional and/or General Liability Insurance Policy? ☐ Yes ☐ No

   If yes, please explain: _____

   _____

VIII. ADDITIONAL INFORMATION

Please attach:

1. Copy of Applicant's letterhead/business stationery;
2. Copy of Applicant's protocol(s) for stabilization and transportation of patients requiring hospital or other care unavailable at the center;
3. Loss History (supply the following):
   a. Claims listing of ten years currently valued, including current year, detailed loss information (preferably in electronic form);
   b. Carrier loss runs to support information in 1.a. above;
   c. Full details of allegation on all losses paid or currently open in excess of $50,000;
4. Most recent accrediting agency (JCAHO, AAAHC) and state licensure report with recommendations and the institution's response to any contingencies. Please provide copy of original report from agency (not the internet summary);
5. Current audited financial statements or pro formas;
6. Medical Staff Bylaws;
7. Transfer Agreements; and
8. Organizational Chart.

IX. NOTICE TO APPLICANT

FRAUD PREVENTION – GENERAL WARNING

NOTICE: Any person who knowingly, or knowingly assists another, files an application for insurance or claim containing any false, incomplete or misleading information for the purpose of defrauding or attempting to defraud an Insurance Company may be guilty of a crime and may be subject to criminal and civil penalties and loss of insurance benefits.

NOTICE TO ARKANSAS, LOUISIANA AND NEW MEXICO APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an Insurance Company for the purpose of defrauding or attempting to defraud the Company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any Insurance Company or agent of an Insurance Company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: Warning, it is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

NOTICE TO KENTUCY APPLICANTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

NOTICE TO MAIN APPLICANTS: It is a crime to provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW YORK APPLICANTS: Any person who knowingly and with intent to defraud any Insurance Company or other person files an application for insurance or statement of claims containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with the intent to defraud any Insurance Company or other person files an application for insurance or statement of claim containing any fact materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NOTICE TO TENNESSEE & VIRGINIA APPLICANTS: It is a crime to knowingly provide false, incomplete or misleading information to an Insurance Company for the purpose of defrauding the Company. Penalties include imprisonment, fines and denial of insurance benefits.

The undersigned represents that he or she is authorized to sign this application on behalf of the applicant and further represents and acknowledges that all information contained in this application, including any supplements and attachments, is true, accurate and complete; will be relied upon by the company in determining whether to insure the applicant and at what rate to insure it; and will be considered part of any policy that is issued.

The undersigned further represents and acknowledges that the policy applied for provides coverage on a claims made and reported basis and, subject to the policy provisions, will apply only to claims or suits that are first made and reported in writing to the company during the policy period unless an extended reporting period applies.

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

ADDITIONAL INFORMATION FORM

Please use the space provided below to provide additional information as required by individual questions in this application.

Use additional sheet(s) if necessary.

Question #	Comments

Signature

Date