

MedAmerica

RISK RETENTION GROUP, INC

MUTUAL

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Walnut Creek, CA 94596

(888) 626-1160

**MEDAMERICA MUTUAL RISK RETENTION GROUP
EMERGENCY MEDICAL GROUP APPLICATION
FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE**

Please note that you are applying for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: 1) arise from incidents or events that happen while the policy is in force and that involve your work at an approved emergency department facility, and 2) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a certificate insert, together with any endorsements that may apply, has been issued.

Please attach a copy of your letterhead and any advertising materials that your group may use.

1. GROUP INFORMATION

A. Group Name _____

B. Key Contact _____ Title _____

C Name of Medical Director _____ Phone _____

Please attach a copy of your contract with the hospital for which you are providing ED services.

D. Name of Approved Medical Facility _____

Group Address _____

City _____ State _____ Zip Code _____ Phone _____

Email _____

Additional Location(s)

E. Name of Approved Medical Facility _____

Address _____

City _____ State _____ Zip Code _____ Phone _____

F. Name of Approved Medical Facility _____

Address _____

City _____ State ____ Zip Code _____ Phone _____

G. Name of Approved Medical Facility _____

Address _____

City _____ State ____ Zip Code _____ Phone _____

H. Type of Group ____ Sole Proprietorship ____ Partnership ____ Professional Corp. ____ Other (explain)

I. Group Tax ID Name _____ Group Tax ID Number _____

J. Contract Holder(s)/Owner(s) _____

K. Total Number in Group ____ Physicians ____ PAs ____ NPs ____ RNs ____ Other (explain)

L. Do you require your physicians to live within a certain radius from the ED? ____yes ____ no

If so, what is the maximum number of miles or minutes that they can they live away from the ED? _____miles _____minutes.

If not, do you have any itinerant physicians traveling from great distances (greater than 1 hour or 60 miles) to work in your ED? ____ yes ____no If so, how many?_____

M. How many of your physicians work for you on a part-time basis? _____

N. What is your turnover rate for physicians that work for you? _____%

O. Do your physicians primarily work at one location? ____yes ____ no

P. Please break out your historical visits by category (ambulatory or emergency) for the past five (5) years. Patient visits are categorized by CPT codes. **Ambulatory care visits are CPT codes 99281, 99282, and 99283 All other visits will be charged the Emergency rate.**

Year	Ambulatory	Emergency

2. COVERAGE REQUEST

A. Requested Effective Date: ____/____/____
Month Day Year (Note this is the date you wish coverage to begin with MedAmerica Mutual)

B. Prior Acts Coverage: (check one)

____ The group does wish to apply for prior acts coverage. (coverage for occurrences and/or accidents which took place prior to the requested effective date listed above.) If so, please fill in the requested retroactive date below.

Requested Retroactive Date ____/____/____
Month Day Year

____ The group does not wish to apply for prior acts coverage. It is understood that by not purchasing prior acts coverage, you acknowledge that you are not covered for claims or suits arising out of treatment rendered prior to your effective date of coverage with MedAmerica Mutual. Tail coverage from your prior carrier must be purchased if you elect not to have MedAmerica Mutual pick up this prior exposure unless your prior exposure was on an occurrence form.

C. Are you, as of this date aware of any claims against you that have not been reported to your present or prior insurer(s)? ____ yes ____ no

D. Are you, as of this date, aware of any conduct, circumstances or incidents that occurred during the period of coverage listed below that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)? ____ yes ____ no

E. Desired Limits of Liability: \$_____/ \$_____
Per Claim Annual Aggregate

3. PREVIOUS INSURANCE

To assure that there are no gaps in coverage, please list all previous medical professional liability insurance carriers for the past five (5) years, beginning with your current carrier. Use the Remarks section to list additional carriers.

Carrier Name	Policy Period	Limits of Liability	Claims-Made/Occurrence

Please attach a copy of your most recent declarations page.

4. ATTESTATION QUESTIONS

If you answer "YES" to any of the following questions, **please give full details** in the Remarks section. Include dates and copies of any related documents.

A. Has the group ever had professional liability insurance declined, non-renewed, cancelled or restricted, or had an involuntary deductible and/or surcharge assessed against it?

yes no

B. Has any physician within the group ever been suspended, restricted or put on probation by any governmental health program (e.g. Medicare or Medicaid)

yes no

C. Has any physician within the group ever undergone a HCFA investigation for an alleged violation of EMTALA?

yes no

D. Has any physician within the group been fined as a result of a HCFA investigation resulting from an alleged violation of EMTALA?

yes no

E. Has any physician within the group ever been treated for alcoholism, narcotics addiction or mental illness?

yes no

F. Has any physician within the group become aware of any chronic illness or physical defect that impairs or could impair his/her ability to practice emergency medicine?

yes no

G. Has any physician within the group ever been investigated by any State Licensing Board, Narcotics Board, DEA or other governmental or regulatory agency or has his/her license to practice or his/her narcotics license ever been denied, revoked, suspended or limited in any way?

yes no

H. Has any physician within the group had any hospital restrict, revoke or invoke probation for any cause other than for incomplete charts?

yes no

I. Has any physician within the group ever been indicted and/or convicted of a crime other than minor traffic violations?

yes no

J. Has the group or any physicians within the group been involved in a malpractice claim, suit or incident in the past 10 years?

yes no If "yes," how many? _____

If you answer "yes" to this question, please provide complete details on the Claim Information Form. Complete a separate form for each claim.

5. GROUP PRACTICE POLICIES

Please indicate if the policies and procedures listed below exist in written form and require mandatory compliance. If none exists, state the alternative or reason or plans to rectify in the remarks section. Please explain all "no" answers on a separate sheet.

	Yes	No	Mandatory	Optional
A. Triage Policy	0	0	0	0
B. Medical Screening Exam	0	0	0	0
C. Transfer (COBRA) Policy	0	0	0	0
D. Clinical Protocols	0	0	0	0
E. Advice Calls				
Triage	0	0	0	0
Medical Screening Exam	0	0	0	0
Transfer	0	0	0	0
Other _____	0	0	0	0
F. CME Programs	0	0	0	0
G. Physicians Compliance & Training of	0	0	0	0
Nurses	0	0	0	0
Ancillary/Extenders	0	0	0	0
H. CQI Program	0	0	0	0
I. Patient Satisfaction Survey	0	0	0	0
Average score? _____				
J. Claims Management	0	0	0	0
Incident Reporting	0	0	0	0
Record & Track Claims	0	0	0	0
Credentialing Protocols	0	0	0	0
K. Medical Records	0	0	0	0
Dictated	0	0	0	0
Electronic	0	0	0	0
Handwritten	0	0	0	0
L. If handwritten, are preformatted charts used?	0	0	0	0
M. Are PDAs used?	0	0	0	0
N. Are Scribes used?	0	0	0	0
O. Mechanism to handle Test Discrepancies:	0	0	0	0
Radiology	0	0	0	0
Lab	0	0	0	0
EKG	0	0	0	0
Safety Mechanisms	0	0	0	0
Security Mechanisms	0	0	0	0
Compliance with COBRA	0	0	0	0
P. What is your average door to doctor time? _____				
Q. What is your average length of stay in the ED for non-admitted patients? _____				
R. What is your average length of stay in the ED for admitted patients? _____				

S. How are patient satisfaction surveys related to performance reviews?

T. What types of procedures do your physicians do outside of the ED for the hospital (if any)?
i.e. admitting orders, placing chest tubes, etc.

6. RISK MANAGEMENT

A. Please submit a copy of your written risk management protocol.

B. What aspects of the protocol are mandatory and how is compliance monitored?

C. Are all physicians American Board Certified in Emergency Medicine? ____ yes ____ no

D. If not, are they American Board Certified in another specialty? (e.g. family practice, internal medicine)
____ yes ____ no

E. How many physicians are not American Board Certified in any medical specialty? ____

F. Is credentialing done for all physicians? ____ yes ____ no
Is credentialing done ____ internally or ____ by a third party?

G. Are risk management courses required? ____yes ____no

H. When a claim or incident occurs, is it peer reviewed? ____yes ____ no

I. What do you do if an on-call physician doesn't respond or is unavailable?

J. Do you have a patient advocacy program? ____ yes ____no

K. Are computerized discharge instructions provided for every patient? ____ yes ____ no

L. What is your requirement for dictating medical records? ____ at end of shift ____w/in 24 hours ____w/in 48 hours ____greater than 48 hours (please specify) _____

M. Do you have a clearly defined transfer procedure? ____yes ____ no

N. Do you have a formal process to reassess, reevaluate, and determine the final disposition of patients who are handed off to other physicians? ____ yes ____ no

7. PHYSICIAN ROSTER

Physicians listed below will be covered under this policy. Failure to list the physicians may jeopardize coverage. Include any departed physicians for whom you may need coverage, along with their date of hire and termination date. If a physician is not American Board Certified in Emergency Medicine, please list the specialty that he/she is American Board Certified in. Attach another sheet if you need more space.

Name Date of Hire Termination Date Phone License-State ABC Specialty

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- 44 _____
- 45 _____

REMARKS: _____

AGREEMENT: I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information and/or material misrepresentation will cause immediate rescission of the Emergency Medical Group's insurance coverage.

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning the Emergency Medical Group's professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, interindemnity arrangement, underwriter and insurance agent to furnish any information concerning the Emergency Medical Group that the company may request.

APPLICANT
SIGNATURE: _____ **DATE** _____

CLAIM INFORMATION FORM: Photocopy and complete this form for each additional claim. If more space is needed on each report, continue information on your letterhead. Please write legibly.

Name of patient _____ Age _____ Sex _____

Relationship to patient (e.g. attending physician, consultant, primary surgeon, assistant surgeon, etc.)

Allegation _____

Date of Incident _____ Location _____

Insurance Carrier _____

Other Defendants _____

Present Status _____ open _____ closed _____ date if closed

Loss of \$ _____ Settlement _____ Judgment _____

Condition and diagnosis at time of incident:

Dates and description of professional services rendered:

Condition of patient subsequent to professional services (and dates of follow-up visits) if known:

I hereby declare the above information is complete and true to the best of my knowledge and belief.

Signed

_____ Date _____