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Healthcare Facility Medical Management Services Professional Liability Supplemental Application

ProAssurance. Treated Fairly

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Management Company: _____ Name: _____

Address: _____

City, State, ZIP: _____

Telephone Number: _____ Fax Number: _____

Contact Name: _____ Contact Email: _____

1. Services Provided by Management Company

A. Is applicant involved in utilization review for others on a fee basis? ☐ Yes ☐ No

If *yes*, please provide answers to the following:

	Last 12 Months	Projected Next 12 Months
Number of cases reviewed:		
Amount of healthcare benefits denied:		
Number of full-time utilization reviewers:		

B. Is applicant involved in providing health care benefit claims handling and adjusting services? ☐ Yes ☐ No

If *yes*, please provide answers to the following:

	Last 12 Months	Projected Next 12 Months
Annual revenues derived from such service:		
Approximate number of claims processed:		
Number of claims denied:		

C. Other management services provided:

- ☐ Payroll Administration
- ☐ Data Processing
- ☐ Accounting
- ☐ Claim Filing
- ☐ Sales and Marketing
- ☐ RM/Loss Control Services
- ☐ Administration
- ☐ Insurance Placement/Consulting
- ☐ Human Resources
- ☐ Legal Services
- ☐ Clerical
- ☐ Supply Procurement
- ☐ Lease Negotiation
- ☐ Contract Negotiation (MCO, Employment, Other)
- ☐ Premium Financial Services
- ☐ Actuarial Services
- ☐ Other (give details):

How long is your standard contract with professional associations? _____

2. Credentialing by Management Company

A. Who is responsible for the credentialing of contracted health care providers?

B. If applicant is involved in credentialing/peer review services for others on a fee basis, what is the total revenue for:

Last 12 months: _____

Projected next 12 months: _____

Number of physicians credentialed or reviewed: _____

C. How often does the re-credentialing process of contracted health care providers take place?

D. If credentialing is subcontracted:

i. Does applicant review the process? ☐ Yes ☐ No

ii. Is the subcontractor required to maintain errors and omissions insurance? ☐ Yes ☐ No

If *yes*, what limits are required by the applicant? _____

iii. Are you added as Additional Insured or provided with Hold Harmless clause? ☐ Yes ☐ No

E. Does applicant query any available data bank on a contracted provider during the credentialing process? ☐ Yes ☐ No

F. Are on-site visits conducted by applicant of contracted health care providers? ☐ Yes ☐ No
How often? _____

G. Are restrictions placed on the practice of any health care provider who has a mental or physical disorder that may impair their ability to practice medicine? ☐ Yes ☐ No

If *yes*, please provide details:

H. Have any providers been removed or disqualified from applicant's approved panel in the past 36 months? ☐ Yes ☐ No

If *yes*, how many? _____

Please provide details:

3. Management Company Personnel

A. Total number of employees: _____

B. Does applicant employ physicians, surgeons or any other clinical health care professionals in any medical capacity except to perform administrative duties, peer review, or utilization review functions? ☐ Yes ☐ No

If *yes*, provide details and schedule of employees: _____

_____

C. Do applicant's legal representatives review and approve all contracts, sales, literature, and brochures prior to their use? ☐ Yes ☐ No

4. Management Company General Information

Fully describe any operations with which you are involved that have not been addressed in prior questions.

5. Schedule of Entities to be Managed

A. Please schedule each entity, hospital, clinic or other health care facility for which management services are provided:

Name	# Beds	# Outpatient Visits

B. Please schedule physician groups and individual physicians:

Name	Specialty

C. Are all contracted health care providers (physicians and others) required to maintain medical malpractice insurance? ☐ Yes ☐ No

If *yes*, what minimum limits are required? _____

6. Insurance Policy Information for Entities to be Managed

Policy Period: From _____ To _____ Retroactive Date: _____

Limits of Liability: _____ Applicable Deductible: _____

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____

Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):

Agent: _____ Phone: _____

Agency: _____ Fax: _____

Address: _____ Email: _____

_____ License No.: _____

Signature: _____

HEALTH CARE FACILITY APPLICATION ADDENDUM

PCF SCHEDULE OF ENTITIES AND D/B/A'S

NOTE: In compliance with the Indiana Patient Compensation Fund Guidelines all eligible entities and business names (D/B/A's) operating under the hospital's license must be scheduled on the Patient Compensation Fund Certificate, and remit the applicable surcharge to be extended coverage by the Patient Compensation Fund. Rating exposures (including but not limited to outpatient visits, one day surgery procedures, home health visits, inpatient days, etc.) of scheduled entities and operations are to be included on the Health Care Facility Application.

Other hospital owned or controlled eligible entities and D/B/A's operating under separate licensure must make separate PCF application, pay applicable surcharge, and meet underlying primary coverage requirements. Failure of the hospital to comply with PCF requirements could result in a declination of coverage by the Patient Compensation Fund.

Name:	**Tax ID #**	**Health Dept License #**