Physicians Regulatory Insurance Program Application

This page provides Instructions and Guidelines for Completing the Audit Insurance Application - This is NOT the application.

Please review the application initially in order to gather the information you will need to complete it properly and completely. Incomplete answers will delay your quotation and proposal, and subsequently, your coverage. Please answer all questions. If a question does not apply, write NA or None.

I. GENERAL INFORMATION

Applicant's Name (If entity please state)

Address

City State Zip Code

Business Phone Fax

Requested Effective Date	Requested Retroactive Period ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 Years ☐ 5 Years ☐ 6 Years

Name of entity as it is to appear on policy documents

Type of entity (i.e. P.A., P.C., LLP, Partnership)

Specialties of practice:

Named entity coverage is available only when all practitioners (employed or contracted) apply.

Please provide the following census information, including all practitioners whether employed or contracted:

Number of Practitioners in Group	Number of Physicians working more than 20 hours per week	Number of Physicians working 20 hours or less per week	Number of Nurse Practitioners/Midwives/ CRNAs	Number of RNs, LPNs and Physician Assistants

- Please list only the principal practitioner(s). List all others on the Census section of the application.

II. PAYOR INFORMATION

Please provide the following information regarding the "Payor Mix" of your practice:

Payor Source	Gross Billings for the past 12 months	Collections for the past 12 months
Medicare	$	$
Medicaid	$	$
Medicare Founded HMO	$	$
All Other (Commercial, Cash, etc.)	$	$
Total	$	$

Total for all Payors should equal gross billings and collections for the entire practice

THIS SECTION MUST BE COMPLETED. The application cannot be submitted to the underwriter without this information. Please provide a combined total for all practitioners. Information must be by "payor mix" as requested, otherwise, risk cannot be determined.

III. BILLING PROCEDURES

Does your practice have a billing compliance program? If answering "no", please describe your billing guidelines on a separate piece of paper	☐ YES ☐ NO
Does your practice have a written policy regarding collection of receivables balances?	☐ YES ☐ NO
If answering "yes", does the policy include write-offs of outstanding balances, co-payments and deductibles?	☐ YES ☐ NO
What edition of the CPT manual are you currently using for your practice?	
Does your practice keep EOB files after they are recorded in the billing system?	☐ YES ☐ NO
Does your practice keep a separate file of outstanding/denied/questioned EOBs?	☐ YES ☐ NO
Are all contracts and referral relationships reviewed by outside counsel to ensure they conform with anti-kickback statutes?	☐ YES ☐ NO
Are billing and procedure codes monitored to alert practice management of possible upcoding, over-utilization or other billing anomalies?	☐ YES ☐ NO
Does your Practice monitor free and / or discounted samples of medications and supplies to guard against co-mingling with purchased inventory or inappropriate billing for items dispensed?	☐ YES ☐ NO
Does the entity/ physician transmit any protected health information electronically?	☐ YES ☐ NO
If yes, does the entity comply with HIPAA's Privacy Rule for Covered entities?	☐ YES ☐ NO
Is any physician required (by medical staff documents at any hospital's emergency department) to serve "on-call" for patients requiring emergency treatment?	☐ YES ☐ NO
If yes, is the physician familiar with their responsibilities under EMTALA as they apply to individual physicians?	☐ YES ☐ NO

- If no billing compliance program, please remember to attach details of your billing guidelines.
- CPT manual must not be more than 2 years old.

If answering "yes" to any of the following questions, please describe in detail, on a separate sheet of paper, each incident.	
Have you or anyone within the entity ever been reviewed by the State Board of Medical Examiners?	☐ YES ☐ NO
Have you or anyone within the entity ever lost any medical practice privileges, other than voluntary termination, with any provider?	☐ YES ☐ NO
Have you or anyone within the entity ever been investigated or sanctioned by any local, state or federal government or agency regarding the delivery of health care services or reimbursement thereof?	☐ YES ☐ NO
Have you or anyone within the entity ever been involved in a stark / anti-kickback investigation?	☐ YES ☐ NO
Have you or anyone within the entity ever been sued or deselected from a commercial payor?	☐ YES ☐ NO

If billing is currently performed by a third party billing company please provide the following information:		
Billing Company's Name		
Address		
City	State	Zip Code
Please describe any common ownership that exists between the Applicant's practice and the third party billing company.		
Does the third party billing company have a compliance program?	☐ YES ☐ NO	

If billing is currently performed in-house please provide the following information:

Number of individuals responsible for billing	* Number of credential billers

* A Credential Biller is one who has completed certification course relative to billing and coding procedures.

- Please remember to attach details when required for "yes" answers. If you have questions or need assistance in completing the application, call our Toll Free Number: 800-867-5767

IV. PROFESSIONAL CENSUS

Please provide a complete list of all professional staff and their designation below. This page may be duplicated as necessary. Signatures are not required in this section. Please type or print legibly.

	Name	Designation	Full Time	Part Time
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

- List all staff here – practitioners, therapists, PAs, billers and all other employees for all offices or locations. The census determines who is covered. Everyone you want/need to be covered MUST be listed on the census. Be sure to include the practitioners counted in Section 1.

INDEPENDENT CONTRACTORS SHOULD NOT BE INCLUDED IN THE CENSUS IF THEY BILL FOR THEIR OWN SERVICES UNDER THEIR OWN TAX ID OR MEDICARE NUMBER.

V. PHYSICIAN/PRACTITIONER WARRANTY (To be completed and signed by an officer of the entity)

An officer of the practice must read the following statement:

The Undersigned warrants and represents that, to the best of his/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 Underwriters 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 Underwriters, 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 Underwriters of such occurrence, event or circumstance, and shall provide the Underwriters 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 Underwriters.

The Underwriters are hereby authorized to make an investigation and inquiry in connection with this application as it may deem necessary.

The Undersigned warrants that they are duly authorized by the by laws of the group or entity to execute this warranty on behalf of the group or entity, and confirms that they have made the necessary inquiries to assure underwriters of the accuracy of the statements made hereon.

An officer of the practice must answer the following two statements, sign and date below. If you cannot agree to either of the following two statements, please attach a detailed explanation.

Statement 1. I agree with the above physician/practitioner warranty.

Statement 2. I have no knowledge of any specific claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the proposed policy.

PLEASE BE SURE TO RESPOND TO BOTH STATEMENTS WHERE INDICATED AND SIGN AND DATE WHERE INDICATED, UNDATED SIGNATURES CANNOT BE ACCEPTED.

Applicant's Name (Please type or print legibly)	Signature / Title	Date	Response to Statement 1	Response to Statement 2
			☐ YES ☐ NO	☐ YES ☐ NO

- You must respond to the two warranty statements. If you answer "no" (cannot agree) to either of the statements, a written detailed explanation is required. Be sure to include signature and date.

Questions? Call us toll free at 800-867-5767

Fax or Email Completed Documents to:
Email: info@medriskusa.com

What Happens Next?

Med-Risk Management Associates will forward your application to the underwriters for review. The underwriters usually provides an answer within one week, unless there is an issue or they require more information.

Once approved, you will receive notification from Med-Risk Management Associates, along with your formal proposal outlining the details of coverage and payment options. The last page of the proposal will have a place for your signature indicating your acceptance**.**

E-mailing the signed acceptance, payment preference and a copy of your check to the insurance agent for the full, or partial premium, binds coverage as of that moment. Also, please e-mail a copy of the signature page and a copy of your check to info@medriskusa.com.

The insurance company will issue you with a one page binder certificate. The signed agreement and your check must be mailed and received by the insurance company within 15 days from the date of binder notification, or coverage will be canceled. If you choose the monthly or quarterly payment option, you will receive additional financing information from the company that services the policy.

You will receive the policy document in the mail 30-60 days from the date the binder was issued.

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