NAS Insurance Services, inc.

Application for: HIPAA Protector and MEDEFENSE PLUS (CLAIMS MADE)

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must notify the insurer, and at the sole discretion of the insurer, any outstanding quotations may be modified or withdrawn.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

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.

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

I. General Information

1. Name of Applicant: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Telephone Number: ( ) _____ Fax Number: ( ) _____

2. Type of entity: ☐ Incorporated ☐ LLC ☐ Partnership ☐ Joint Venture ☐ Sole Proprietorship ☐ Non Profit ☐ Other
   If Other, describe: _____

3. If the entity cited above is a partnership, who is the General Partner? _____

4. Date of the formation of the entity cited above: _____

5. Nature of business operations: ☐ Physician ☐ Medical Group ☐ Hospital ☐ Billing Entity ☐ Other _____

   _____

6. Other operational locations and descriptions **(Use separate sheet if necessary):**

   _____

   _____

   _____

7 Are you a "Covered Entity" under the Health Insurance Portability and Accountability Act (HIPAA)? ☐ Yes ☐ No

8. Annual Revenues: Current Year _____ One Year Ago _____ Two Years Ago _____

9. Do you have independent audited financials? ☐ Yes ☐ No
   Please attach a copy of your financial statements, whether audited or unaudited.

10. Do you have Directors and Officers Liability Insurance or Partnership Errors and Omissions insurance? ☐ Yes ☐ No

11. Do you have Managed Care Errors and Omission insurance? ☐ Yes ☐ No

II. Compliance

1. a. Which compliance/audit software system do you utilize? _____
   b. When was it installed? _____

2. Do you have a Compliance program in place? ☐ Yes ☐ No
   a. For Billing Errors? ☐ Yes ☐ No
      If Yes, when was it implemented? _____ **Please provide a copy.**
      If No, please explain why: _____
      Are you willing to implement one? ☐ Yes ☐ No
      If Yes, within what time frame: _____
   b. For HIPAA? ☐ Yes ☐ No
      If Yes, when was it implemented? _____ **Please provide a copy.**
      If No, please explain why: _____
      Are you willing to implement one? ☐ Yes ☐ No
      If Yes, within what time frame: _____

   c. Do you give each patient notification of their privacy rights? ☐ Yes ☐ No

3. Do you have a compliance officer/manager? ☐ Yes ☐ No
   a. If Yes, who is it, how is he/she qualified, and to whom does he/she report? _____

   b. If No, who ensures compliance? _____

4. Do you use an outside compliance consultant? ☐ Yes ☐ No
   If Yes, who? _____

5. Who is your legal counsel for compliance issues? _____

6. Who is your CPA firm for compliance issues? _____

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

After completing Sections I and Section II, please fill out only the following Section(s) which refer(s) to your category(ies).

III. Physician/Medical Group

1. a. Do you have a group affiliation? ☐ Yes ☐ No
      If Yes, please describe: _____

   b. How many physicians make up your group? _____

   c. How many physicians are on your staff in your group? _____
      What is/are your specialty/specialties? **(Use separate sheet if necessary)**

2. Have you acquired any practices in the last 5 years? ☐ Yes ☐ No
If Yes, please provide specific details, including size, dates, what specialty/specialties were involved and what the Medicare/Medicaid billings were as a percentage of the total practice for each of the past five years.
(Use separate sheet if necessary)

3. Please attach a listing of Medical Malpractice Insurers and policy limits of all physicians in your group.

4 a. 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 Medicare/Medicaid billings been for each of the past three years?

Year	***Amount***

5. Do you handle billings for any hospitals? ☐ Yes ☐ No
If Yes, please describe these services on a separate sheet.

6. Medicare Provider Number: _____ Any other Medicare/Medicaid provider numbers? ☐ Yes ☐ No
If Yes, for which entity(ies)? _____

Please list separate number(s) and corresponding entity(ies).

7. Have you ever used a contingency fee based billing consultant? ☐ Yes ☐ No
If Yes, please explain: _____

IV. Hospital

1. **Type of Institution**:

☐ Acute Care Hospital ☐ Teaching Hospital ☐ Community Teaching Hospital ☐ Community Hospital
☐ For Profit ☐ Non Profit

2. Do you own any physician groups? ☐ Yes ☐ No
Date(s) acquired or incepted: _____

3. Gross Revenues: _____
Gross Medicare Revenue: _____
Total number of Medicare billings:
2001: _____
2002: _____
2003: _____

Gross Medicaid Revenue: _____
Total number of Medicaid billings:
2001: _____
2002: _____
2003: _____

4. **In-patient**:

a. Number of beds: _____
b. Average length of stay: _____
c. Occupancy Rate (%): _____
d. % of Medicare/Medicaid admissions to total admissions: _____

5. **Out-patient**:

a. Number of out-patient bills: _____
b. Estimated % of bills to Medicare: _____
c. Estimated % of bills to Medicaid: _____
d. Billing as a % of Medicare bills: _____
e. Total number of physicians employed: _____

Number of physicians employed by the following services:

Emergency services _____
Medical services _____
Surgical services _____
Laboratory services _____
Home health care services _____
Physicians _____
Other _____

6. Medicare Provider Number: _____ Any other Medicare/Medicaid provider numbers? ☐ Yes ☐ No
If Yes, for which entity(ies)? _____

Please list separate number(s) and corresponding entity(ies).

_____

7. Have you ever used a contingency fee based billing consultant? ☐ Yes ☐ No
If Yes, please explain: _____

_____

V. Billing Entity and All Other Entities

1. Description of services provided/performed: _____

_____

_____

2 a. 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 Medicare/Medicaid billings been for each of the past three years?

Year	***Amount***
_____	_____
_____	_____
_____	_____

3. Do you handle billings for any hospitals? ☐ Yes ☐ No

If Yes, please describe these services on a separate sheet.

4. Do you have a Medicare provider number? ☐ Yes ☐ No
If Yes, please provide: _____

VI. Experience

To be completed by all Applicants.

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

1. Been investigated or sanctioned by any local, state or federal government agency or private payor regarding the delivery of health care services or reimbursement thereof? ☐ Yes ☐ No

2. Had to refund amounts to Public and/or Private payers? ☐ Yes ☐ No
   If Yes, how much? Public: $ _____ Private: $ _____

3. Been audited or investigated with regard to Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? ☐ Yes ☐ No

4. Been accused of errors by any government agency or commercial payer? ☐ Yes ☐ No

5. Do you have knowledge of any claims or facts, circumstances, situations, events or transactions that may result in a claim which may be covered by the proposed policy? ☐ Yes ☐ No

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

The undersigned warrants and represents that, to the best of his or 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 insurer 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 insurer, any insurance issued shall be void in its entirety.

The undersigned agrees that if after the date of this Application and prior to issuance, any occurrence, event or other circumstance should render any of the information contained in this Application inaccurate or incomplete, the undersigned shall notify the insurer of such occurrence, event, or circumstance and shall provide the insurer 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 insurer.

The insurer is hereby authorized to make any investigation and inquiry **in connection with this Application** as it may deem necessary.

Severability: No knowledge or information processed by any insured person will be implied to any other insured person except for materials 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.

BY	**TITLE**	**DATE**

NAS Insurance Services, inc.

Form NAS MED + App 5-04