

SOLO PHYSICIANS ONLY
THIS IS AN APPLICATION FOR CLAIMS MADE AND REPORTED
PHYSICIANS BILLING ERRORS AND OMISSIONS INSURANCE

(Complete this form only if you are purchasing MEDefense Plus coverage)

This insurance does not apply to billing errors for medical services or items which are not provided or prescribed by you. 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must notify the Insurer, and at the sole discretion of the Insurer, any outstanding quotations may be modified or withdrawn.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 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 policy, unless otherwise stated.

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.

I. GENERAL INFORMATION

A. Physician Applicant Name: _____ CAP No. _____

Business Phone: (____) _____ Business FAX: (____) _____

B. What is the Physician Applicant's Specialty: _____

II. BILLING SERVICES

A. Total Gross Annual Revenue \$_____. Approximately, what percentage of the Physician Applicant's Gross Annual Revenue is billed to a Federal or State health care program, such as Medicare or Medicaid? _____

B. Does the physician applicant use an outside billing service or compliance audit software? Yes No

III. MISCELLANEOUS (If any answer is yes, please explain on a separate sheet of paper).

A. Has the Physician Applicant 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

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

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

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

IV. CLAIMS OR POTENTIAL CLAIMS

Does the Physician Applicant have knowledge of any specific Claims or facts, circumstances, situations, events or transactions (for the past 5 years) that may result in a claim which may be covered by the proposed policy? Yes No

V. WARRANTIES AND REPRESENTATIONS

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 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 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 an investigation and inquiry in connection with this Application as it may deem necessary.

PHYSICIAN APPLICANT SIGNATURE _____ **DATE** _____