MEDEFENSE™ Plus Supplemental Application

Claims Made Basis. Underwritten by Underwriters at Lloyd's, London

The Insurer agrees to use all information provided in this Supplemental 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must notify the insurer, and at the sole discretion of the insurer, any outstanding quotations may be modified or withdrawn.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 Supplemental 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.

The Applicant is required to make internal inquiry before completing this Supplemental Application. This Supplemental 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.

"You" and "your" as used in this Supplemental Application shall mean the Applicant.

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

SECTION I. GENERAL INFORMATION

1. Name of Applicant: _____

   Principal Address: _____

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

   Corporate Website Address: _____ Email: _____

2. Nature of business: _____

3. Number of physicians (if applicable): _____ Specialty: _____

4. Gross Revenue estimate for coming year: $_____

5. Please provide a list of subsidiaries and entities owned by the Applicant. Please describe the nature of business of each such subsidiary or entity, its relationship to the Applicant, and the percentage of ownership by the Applicant.

   _____

   _____

6. Have you acquired any practices in the last 5 years? ☐Yes ☐No

   If you answered **"YES**" to question 6, please provide specific details, including the size of the practice(s), date(s) of acquisition, specialty/specialties, and percentage of Medicare/Medicaid billings for each practice for each of the past five years.
   (Please use a separate sheet of paper, if necessary):

   _____

   _____

7. a) Applicant's 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 your Medicare/Medicaid billings been for each of the past three years?

   Current Year: _____ One Year Ago: _____ Two Years Ago: _____

8. Have any officers or senior management voluntarily or involuntarily left your employ within the last 18 months? ☐Yes ☐No

If you answered "**YES**" to question 8, please provide details, including the exact date (mm/dd/yyyy) of the separation, the name and the title of the individual, and the reason they discontinued employment. **(Please use a separate sheet of paper if necessary)**:

_____

_____

SECTION II. BILLING COMPLIANCE AND NETWORK SECURITY/PRIVACY CONTROLS

9. Do you have a billing compliance program in place? ☐Yes ☐No

If you answered "**YES**" to question 9, when was it implemented? _____

If you answered "**NO**" to question 9, please describe your billing procedures on a separate sheet of paper.

10. Do you use certified billers? ☐Yes ☐No

11. Is your practice using a current edition of the CPT manual? ☐Yes ☐No

12. Is software used to ensure compliance? ☐Yes ☐No

If you answered "**YES**" to question 12, when was it installed? _____

13. Do you have a Billing Compliance Officer? ☐Yes ☐No

If you answered "**YES**" to question 13, what is their title, qualifications and date of hire in this position?

_____

_____

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

15. Do you enforce privacy and security policies that must be followed by all employees, contractors, or other individuals or organizations with access to your patients' information? ☐Yes ☐No

16. Do your privacy and security policies include mandatory training for all employees? ☐Yes ☐No

17. Are all contracts and referral relationships reviewed by outside counsel to ensure you are compliant with anti-kickback statutes/regulations? ☐Yes ☐No

If you answered "**Yes**" to question 17, please provide the date of last review? _____

SECTION III. LOSS HISTORY

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

18. Been investigated or sanctioned by any local, state or federal government agency or private (commercial) payer regarding the delivery of health care services or reimbursement thereof? ☐Yes ☐No

19. Had to refund amounts to Public and/or Private Payers within the last 3 years? ☐Yes ☐No

a) If you answered "**YES**" to question 19, please provide estimated amounts:

Current Year (Fiscal): Public: $_____ Private: $_____

Last Year (Fiscal): Public: $_____ Private: $_____

Two Years Ago (Fiscal): Public: $_____ Private: $_____

b) If you answered "**YES**" to question 19, were these refunds due to: an audit, allegation of improper billing or voluntary self-disclosure? ☐Yes ☐No

20. Been sued or deselected from a private (commercial) payer? ☐Yes ☐No

21. Been:
    a) Audited or investigated for Medicare/Medicaid billing practices or utilization of Medicare/Medicaid services? ☐Yes ☐No
    b) Placed on prepayment review by any local, state or federal government agency? ☐Yes ☐No
    c) Placed on prepayment review by any private (commercial) payer? ☐Yes ☐No
22. Been reviewed, investigated or sanctioned by a state medical licensing board? ☐Yes ☐No
23. Ever lost medical practice privileges, other than voluntary termination? ☐Yes ☐No
24. Been involved in a stark/anti-kickback investigation? ☐Yes ☐No
25. Been accused of billing errors by any government agency or commercial (private) payer? ☐Yes ☐No
26. Been investigated for HIPAA or EMTALA violations? ☐Yes ☐No
27. Had insurance of this type placed on extension, non-renewed or declined? ☐Yes ☐No
28. Been aware of any facts, circumstances, situations, events or transactions that could result in a regulatory action, regulatory investigation or demand for restitution? ☐Yes ☐No

If any of your answers to questions 18 through 28 is "YES", please explain on a separate sheet of paper

I understand that the information submitted herein becomes a part of my Application, and in the event that coverage is bound, is subject to the same warranty and conditions.

Authorized Signature (Must be signed by the Applicant's President, CEO or COO):_____

Printed Name of Signor:_____

Title of Signor:_____

Date:_____