NAS INSURANCE SERVICES
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Encino, CA 91436
LIC #0677191
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MEDEFENSE™ PLUS Supplemental Application

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

Name of Applicant: _____

Description of Operations: _____

1. If you are a physician/medical group, how many physicians make up your group? _____

   Please list specialty: _____

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)**

3. 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?

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

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

COMPLIANCE

1. a. Do you have a billing compliance program in place for Billing Errors? ☐ Yes ☐ No
   If "Yes", when was it implemented? _____
   If "No", please explain why: _____

   b. Do you have a billing compliance program in place for HIPAA? ☐ Yes ☐ No
   If "Yes", when was it implemented? _____
   If "No", please explain why: _____

2. Who is responsible for compliance? _____

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

LOSS HISTORY

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 payer 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. Has the Applicant received any complaints, claims or been subject to litigation involving matters of privacy injury, identity theft, denial of service attacks, computer virus infections, theft of information, damage to third party networks, or the Applicant's customers' ability to rely on the Applicant's network?. **If "Yes", please provide specific details on a separate page.** ☐ Yes ☐ No

6. 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

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 an Executive): _____

Printed Name of Signor: _____

Date: _____