Emergency Physicians Insurance Exchange • Risk Retention Group
2501 Parmenter Center Suite 100B • Middleton, WI 53562 • Toll Free: 866.374.2467

URGENT CARE MEDICAL GROUP APPLICATION
FOR CLAIMS-MADE PROFESSIONAL LIABILITY INSURANCE

Please note you are applying for a claims-made policy form of professional liability insurance. The coverage of this policy is limited to liability only for those claims that: 1) arise from incidents or events that happen while the policy is in force and that involve your work at an approved facility, and 2) are first made against you and are reported to the company while the policy is in force.

Insurance coverage is subject to underwriting approval and payment of the initial premium billing. No coverage exists until the initial premium is received and a certificate, together with any endorsements that may apply, has been issued.

1. GROUP INFORMATION

A. Group Name _____

Type of Group: ❑ Sole Proprietorship ❑ Partnership ❑ Professional Corp.

❑ Other (explain) _____ Date of Formation _____

Group Address _____ City _____ State_____Zip Code_____

Phone _____Website Address _____

B. Primary Contact (Group Leader responsible for Malpractice Insurance decisions):

_____ Title _____

Phone _____ Email _____

C. Secondary Contact (Assigned to handle change requests to the policy on your behalf):

_____Title _____

Phone _____ Email _____

D. Group Tax ID Name _____ Group Tax ID Number _____

E. List of Owner(s) _____

_____

F. Total Number in Group: _____ Physicians _____PAs _____ NPs _____ RNs
_____ Other (explain) _____

G. Are your group physicians: ❑ Employees ❑ Independent Contractors ❑ Mix of Both
❑ Owners / Shareholders

H. Do your contracted facilities allow physicians or advanced practice providers to practice without evidence of medical malpractice insurance?
[If yes, please explain in the Remarks section.] ❑ Yes ❑ No

I. Do you allow temporary privileges for physicians or advanced practice providers in your facilities prior to completion of the credentialing process? ❑ Yes ❑ No
[If yes, please explain in the Remarks section.]

J. Please respond to the following questions regarding Advanced Practice Providers:

a. How are the patients to be treated by a Nurse Practitioner and/or a Physician Assistant? [Check the most appropriate response(s)]:

- ❑ By a clearly defined scope-of-practice for APPs that outlines conditions that can be seen independently
- ❑ Co-manage patients with the physician and do not treat patients independently
- ❑ Request consultation or discuss cases with the physician as needed
- ❑ Are only assigned to care for patients triaged to a level 4 or 5
- ❑ Only work in a low acuity area
- ❑ All patients seen by an APP must be discussed with a physician prior to being discharged
- ❑ Other (describe) _____

b. What is your mechanism to ensure that the APP scope-of-practice is within the group's expectations?

_____

_____

2. FACILITY CONTRACTS

Total Number of Contracts: ____ *Please attach a copy of your contract with each facility for which you are providing services (If applicable).*

***Patient Visits** are to be submitted based on the following:

1. Emergency Department Visits (ED) are patient encounters for medical professional services rendered within a standalone Emergency Department or within a hospital based ED. Patient visits coded as CPT 99284, 99285 or 99291 are defined as ED Visits.
2. Urgent Care Visits (UC) are patient encounters for medical professional services rendered within a hospital based ED and or Fast Track. Patient visits coded as CPT 99281, 99282 or 99283 are defined as UC Visits.
3. Urgent Care Visits within a standalone Urgent Care facility (UC-STANDALONE) are defined as patient encounters for medical professional services rendered at an urgent care facility that is not located within a hospital or hospital campus. Patient visits may be coded as CPT 99201 - 99205 and 99211 - 99215 and are defined as UC-STANDALONE.
4. Primary Care/Occupational Medicine Visits are patient encounters for primary or occupational medicine professional services rendered outside of an Emergency Department or Urgent Care setting.

Patients who leave without being seen are not to be included; however, patients who leave against medical advice are to be included and submitted within the applicable location visit counts above.

A. Name of Medical Facility _____

Facility Address _____ City _____ State_____Zip Code_____

Name of Medical Director or Equivalent _____

Phone _____ Email _____

Original Start Date of Contract _____/_____/_____ Coverage Limits _____occurrence/_____aggregate

Please provide a breakdown of your outpatient visits by the below acuity level(s):

Year (policy ending)	Total # of Patient Visits	Total # of *ED Visits	Total # of *Urgent Care/Fast Track Visits	Total # of *Standalone Urgent Care Visits	Total # of *Primary Care/Occupational Medicine Visits
Projected next 12 months					
Actual past 12 months					

B. Name of Medical Facility _____

Facility Address _____ City _____ State_____Zip Code_____

Name of Medical Director or Equivalent _____

Phone _____ Email _____

Original Start Date of Contract _____/_____/_____ Coverage Limits _____occurrence/_____aggregate

Please provide a breakdown of your outpatient visits by the below acuity level(s):

Year (policy ending)	Total # of Patient Visits	Total # of *ED Visits	Total # of *Urgent Care/Fast Track Visits	Total # of *Standalone Urgent Care Visits	Total # of *Primary Care/Occupational Medicine Visits
Projected next 12 months					
Actual past 12 months					

(*Please list additional Urgent Care Medical Facility(s) on a separate sheet of paper)*

3. GENERAL INFORMATION

A. Which best describes your facility and average distance to a hospital Emergency Department?

Type of Facility	Definition	YES/NO	Distance to Hospital Emergency Department
Convenience Care Center	Medical treatment is limited to non-emergent care similar to a physician's office. Nurse practitioners and/or physician assistants typically staff facility. Examples of ailments treated include coughs, earaches, flu symptoms, ear and eye infections, sinus, bladder infections, bronchial infections, minor wounds and abrasions. Typically offer vaccinations services.		
Urgent Care Center	Services provided may be broader than those typically found in physician's office. Services include onsite x-ray and clinical lab. Physicians regularly staff the facility with the support of advanced practice clinicians and nurses. Examples of ailments treated include those found in Convenience Care Centers plus nosebleeds, fever, abrasions, rashes, animal and insect bites, minor burns, minor fractures, minor lacerations and sprains		
Emergent Care	Provide short-term care for minor medical emergencies needing immediate treatment. Services include onsite x-ray, CT, and clinical lab. Physicians regularly staff the facility with the support of advanced practice clinicians and nurses. Examples of ailments treated include those found in Urgent Care Centers and may expand to include eye injuries, asthma attacks, abdominal pain, vomiting, diarrhea, dehydration, skin infections, allergic reactions, breathing difficulties, chest pain or pressure, back and neck pain, fractures, breathing difficulties.		
Other (if different than above)	Describe the operation and services provided. Note the nature and extent of operations dealing with those not listed above including: Workers Compensation and occupational medicine; surgical procedures; medispa treatments		

B. Within the next 12 month period, does applicant plan to:

1. Obtain another operation or entity? ❑ Yes ❑ No
2. Expand the number of locations? ❑ Yes ❑ No
3. Eliminate/add services? ❑ Yes ❑ No

4. COVERAGE BEING APPLIED FOR

A. Requested Coverage Effective Date: _____/_____/_____

B. Prior Acts Coverage (not available if current coverage is on occurrence form):
Please check one:

❑ The group does wish to apply for prior acts coverage (coverage for occurrences and/or accidents which took place prior to the requested effective date listed above.)

1. ***Requested retroactive date:*** _____/_____/_____
2. ***Please submit a copy of your current policy contract.***
3. ***Summarize and provide a breakdown of your historical visits (all) for the ending policy year for the past seven (7) years. Provide the below information for each location:***

Year (policy ending)	Total # of Patient Visits	Total # of *ED Visits	Total # of *Urgent Care/Fast Track Visits	Total # of *Standalone Urgent Care Visits	Total # of *Primary Care/Occupational Medicine Visits

❑ The group does **NOT** wish to apply for prior acts coverage. It is understood that by not purchasing prior acts coverage, you acknowledge that EPIX will not provide any coverage for claims or suits arising out of treatment that you rendered or failed to render prior to your effective date of coverage with EPIX. If your prior coverage was on a claims-made basis, Tail coverage from your prior carrier must be purchased if you elect not to have EPIX pick up this prior exposure.

C. Are you, as of this date, aware of any claims against you that have not been reported to your present or prior insurer(s)? ❑ Yes ❑ No [*If yes, please explain in Remarks section*]

D. Are you, as of this date, aware of any conduct, circumstances or incidents that occurred during the periods of coverage listed below that could reasonably be expected to result in a claim, and that have not been reported to your present or prior insurer(s)? ❑ Yes ❑ No [*If yes, please explain in Remarks section*]

5. PREVIOUS INSURANCE

To assure there are no gaps in coverage, please list all previous medical professional liability insurance carriers for the past five (5) years, beginning with your current carrier. Use the Remarks section to list additional carriers:

Carrier Name	Policy From	Period to	Limits of Liability	Claims Made/ Occurrence	Tail Coverage Purchased?		Annual Premium Paid
					Yes	No	
					❑	❑	
					❑	❑	
					❑	❑	
					❑	❑	

6. LICENSURE and ACCREDITATION/CERTIFICATION

A. Is the organization licensed by the state to provide urgent services?
❑ Yes ❑ No ❑Not Available by State

B. Is the organization licensed by the state to provide emergent services?
❑ Yes ❑ No ❑Not Available by State

C. Indicate accreditation and most recent survey date (as applicable)

❑ AAUCM_____ ❑AAAHC_____
❑TJC_____ ❑NAFAC_____
❑UCAOA_____ ❑Other_____

D. Were any deficiencies cited in the most recent surveys? ❑ Yes ❑ No
E. Is this a new operation? ❑ Yes ❑ No

7. RISK MANAGEMENT/QUALITY ASSURANCE

A. Who has the overall responsibility for Risk Management & Quality Assurance?
Name:_____Title_____
Telephone:_____E-Mail:_____

B. Does applicant utilize a formal written Quality Improvement Plan? ❑ Yes ❑ No
C. Does the applicant utilize a formal written Risk Management Program/Patient Safety Program? ❑ Yes ❑ No
D. Is there a formal, documented peer review and credentialing process in place for physicians and advanced practice clinicians? ❑ Yes ❑ No
E. If there is more than one location, do you have common P&Ps, RM and QA plans? ❑ Yes ❑ No
F. Medical/Patient Records
  a. Do you utilize an ❑Electronic Medical Record System or ❑Paper files or ❑both?
G. Is a formal, documented patient triage program in place? ❑ Yes ❑ No
H. Are formal, documented procedures followed if a patient presents in an emergency situation? ❑ Yes ❑ No
I. Do you have a Patient Follow-up/Call-back Procedure that requires a documented call to the patient within 48 hours of the visit? ❑ Yes ❑ No

8. BIOMEDICAL EQUIPMENT PREVENTATIVE MAINTENANCE

A. Does the applicant have a formal documented preventative maintenance management program that includes the following elements?
  a. Preventative Maintenance for medical devices conducted by trained personnel ❑ Yes ❑ No
  b. Readily available copies of all user/operator equipment manuals ❑ Yes ❑ No
  c. Recall and hazard alert program ❑ Yes ❑ No

9. ATTESTATION QUESTIONS

If you answer "Yes" to any of the following questions, please give full details in the Remarks section. Include dates and copies of any related documents. Please attach additional pages as may be necessary.

A. Has the group ever had professional liability insurance declined, non-renewed, cancelled or restricted, or had an involuntary deductible and/or surcharge assessed against it? ❑ Yes ❑ No

B. Has any provider within the group ever been suspended, restricted or put on probation by any governmental health program (e.g. Medicare or Medicaid)? ❑ Yes ❑ No

C. Has any provider within the group ever been or is currently being treated for alcoholism, narcotics addiction or mental illness? ❑ Yes ❑ No

D. Has any provider within the group ever been or is currently in a provider health or diversion program? ❑ Yes ❑ No

E. Is any provider within the group aware of any health problem, illness, or physical condition that impairs or could impair his/her ability to safely practice medicine? ❑ Yes ❑ No

F. Has any provider within the group ever been or is currently being investigated by any State Licensing Board, Narcotics Board, DEA or other governmental or regulatory agency or has his/her license to practice or his/her narcotics license ever been denied, revoked, suspended or limited in any way? ❑ Yes ❑ No

G. Has any provider within the group ever had hospital privileges suspended, denied, revoked, restricted or otherwise sanctioned? ❑ Yes ❑ No

H. Has any provider within the group ever been indicted and/or convicted of a crime other than minor traffic violations? ❑ Yes ❑ No

I. Has the group or any providers within the group been involved in a malpractice claim, suit or incident? ❑ Yes ❑ No

If "Yes," how many?_____

Please provide a current loss run from each prior insurance carrier. Please have the provider provide complete details (full narrative) on the Claim or Incident Supplemental Information Form. A separate form should be completed for each claim.

10. PROVIDER ROSTER
Please list all active and terminated physicians and advanced practice providers on the attached provider roster.
Total # listed: _____

11. Please submit an application and CV for all providers.

12. REMARKS: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NOTE: THE POLICY YOU ARE APPLYING FOR IS ISSUED BY A RISK RETENTION GROUP. A RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

AGREEMENT: I agree that this application is incorporated by reference into and becomes a part of the claims made policy that will be issued to my group, should this application be accepted. I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the company in considering this application for professional liability insurance. Erroneous information and/or material misrepresentation will cause immediate rescission of the medical group's insurance coverage.

AGREEMENT: I understand that in order to underwrite professional liability insurance, the company must have access to all possible information concerning the medical group's professional conduct and experience. I hereby authorize and direct any medical society, medical doctor, advanced practice provider, hospital, residency program, insurance company, inter-indemnity arrangement, underwriter and insurance agent to furnish any information concerning the medical group that the company may request.

NO KNOWN CLAIM STATEMENT: The undersigned warrants that as of the date of the signature acknowledgement below, all known claims or suits for incidents which occurred between the retroactive dates being requested and the date this statement is signed, and all acts, incidents and/or circumstances, of which named insured, its agents, employees or physician or advanced practice provider contractors are aware, and which might reasonably be expected to result in a claim under the Prior Acts coverage afforded by the policy, were disclosed in writing to **ALL PRIOR CARRIERS** prior to binding of such coverages.

Further, the undersigned acknowledges and agrees that any such claim resulting from acts committed prior to the binding of coverage, and which named insured, its agents, employees or physician or advanced practice provider contractors were aware, are specifically excluded from this policy.

This warranty is material to the acceptance of coverage by Emergency Physicians Insurance Exchange Risk Retention Group and is made part of the insurance policy.

ACKNOWLEDGED AND AGREED:

SIGNATURE:_____ DATE:_____

PRINTED NAME: _____ TITLE OF OFFICER: _____

CLAIM OR INCIDENT SUPPLEMENTAL INFORMATION

Photocopy and complete this form for each claim or incident. If more space is needed on each report, continue information on your letterhead. Please write legibly.

URGENT CARE GROUP _____

Name of Patient _____ Age _____ Sex _____

Name of Physician _____

Relationship to patient: ❑ attending physician ❑ Other _____

Other Healthcare Providers involved in the claim or incident _____

Allegation(s) _____

Date of Incident ____/____/____ Date Reported ____/____/____ Location _____

Insurance Carrier _____

Defense Counsel _____
(name) (phone)

Present Status ❑ Open ❑ Closed ____/____/____ closed date, if closed

Is this an: ❑ Incident ❑ Claim (Written Demand for damages) ❑ Suit

Loss of $ _____ Settlement _____ Judgment _____

Please provide clinical detail as to condition and diagnosis at time of incident

_____

_____

_____

Dates and detailed description of professional services rendered

_____

_____

_____

Condition of patient subsequent to professional services (and dates of follow-up visits) if known, including the type of injury and any resulting impairments

_____

_____

_____

I hereby declare the above information is complete and true to the best of my knowledge and belief.

GROUP MEDICAL DIRECTOR SIGNATURE OR AUTHORIZED SIGNER _____

NAME AND TITLE OF SIGNATOR _____ Date ____/____/____

URGENT CARE GROUP APPLICATION- PROVIDER ROSTER

UC Medical Group Name:
Physicians and advanced practice providers listed below may be covered under this policy. Failure to list the physicians and advanced practice providers may jeopardize coverage. Include any departed physicians and advanced practice providers for whom you may need coverage. Duplicate this sheet if you need more space.

Provider Name	Title (MD/DO or PA/NP)	Retroactive Date	Start Date	Termination Date