HEALTHCAREPros
Insurance Solutions for Healthcare Service Providers

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Physicians Billing Application

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must notify the insurer, and at the sole discretion of the insurer, any outstanding quotations may be modified or withdrawn.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 for each of the past 3 years:

Year	Amount
_____	_____
_____	_____
_____	_____

9. Total Number of Providers: _____

10. Do you have independent audited financials? ☐Yes ☐No

Please attach a copy of your financial statements, whether audited or unaudited.

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

12.. 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

   If Yes, who is it, how is he/she qualified, and to whom does he/she report? _____

   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. Do you have a group affiliation? ☐Yes ☐No

   If Yes, please describe: _____

   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. Total annual projected billings:_____

   Percentage of annual projected billings attributable to Medicare Patients: _____ %

   Percentage of annual projected billings attributable to Medicaid Patients: _____ %

   What have Medicare/Medicaid billings been for each of the past three years?

Year	Amount
_____	_____
_____	_____
_____	_____

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

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

5. 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):

_____

_____

6. 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. Total annual projected billings:_____

Percentage of annual projected billings attributable to Medicare Patients: _____ %

Percentage of annual projected billings attributable to Medicaid Patients: _____ %

What have Medicare/Medicaid billings been for each of the past three years?

Year	Amount
_____	_____
_____	_____
_____	_____

4. 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).

_____

_____

5. 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. Total annual projected billings: _____

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 healthcare 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.

Name of Applicant or Authorized Signer _____

Signature of Applicant or Authorized Signer_____

Date _____