Regulatory Proceedings Coverage Application
(Medical Defense)

SECTION I GENERAL INFORMATION

1. Name of Applicant:____

   Address:____

   City:____________________ State:______________ Zip:________________

   Telephone no.: (______) ______________ Fax no.: (_____)____________________

2. Do you have independent audited financials? ________Yes _______ No

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

   Do you have Directors and Officers Liability Insurance or Partnership Errors and Omissions insurance?
   ________Yes _______ No

   Do you have Managed Care Errors and Omissions insurance? ________Yes _______ No

SECTION 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 for the following (**Use separate sheet if necessary**):

			If yes, Date Implemented?
Medicare/Medicaid (CMS)	________Yes	_______ No	____________________
HIPAA/HITECH	________Yes	_______ No	____________________
OSHA	________Yes	_______ No	____________________
CLIA	________Yes	_______ No	____________________
EMTALA/Patient Anti-Dumping	________Yes	_______ No	____________________
ADA	________Yes	_______ No	____________________

3. Do you give each patient notification of their privacy rights? ________Yes _______ No

4. 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? ____

5. Do you use an outside compliance consultant? ________Yes _______ No

   If "Yes," who? ____

6. How often are billing reviews performed and by whom? ______________________________

7. Medicare Provider Number: ____

   Any other Medicare/Medicaid provider numbers? ________Yes _______ No

SECTION III – 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 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. 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.

Coverage is now exclusively offered through Advocate MD Risk Purchasing Group, Inc. (Advocate MD RPG), for Texas health care providers insured through Advocate, MD Insurance of the Southwest Inc. Payment of your premium constitutes consent to membership in Advocate, MD RPG and will not require membership fees. Participation in Advocate MD RPG will not affect your current coverage, policy, or claims handling from Advocate, MD Insurance of the Southwest Inc.

Note: Texas law provides that an insurer providing coverage to a purchasing group that is licensed and has capital and surplus in excess of $25 million would be protected by insolvency guaranty fund protection. Advocate, MD Insurance of the Southwest Inc. is the insurer providing coverage to Advocate, MD RPG, has capital and surplus in excess of $25 million, and thus meets this requirement. A risk-purchasing group in Texas may not be subject to all of the insurance laws and rules of Texas and may not be protected by insurance insolvency guaranty fund protection.

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 if after the date of this Application and prior to issuance, any occurrence, event, or other circumstances 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.

______________________________ ______________________________

Signature Date

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Print Name