



Treatment Centers Supplemental Application New Business

Instructions:

- This application must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments Section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

Name of Applicant: _____
 (Whenever used, the term "Applicant" shall include all entities proposed for coverage.)

Indicate the type of service(s) provided by the Applicant and complete the sections as instructed.

TYPE OF SERVICE

- College/University Health Center
- Community Health Center
- Convenience Care/Retail Clinic
- Municipal Health Department
- UrgiCenter
- Dialysis Center
- Oncology Services
- Medi-Spa
- Optical Establishment
- Sleep Lab
- Weight Loss Center

APPLICATION INSTRUCTIONS

- Complete Sections A and B
- Complete Sections A and B
- Complete Sections A and B
- Complete Sections A and B
- Complete Sections A and B
- Complete Sections A and C
- Complete Sections A and C
- Complete Sections A and D
- Complete Sections A and E
- Complete Sections A and F
- Complete Sections A and G

A. General Information

1. Specify where services are provided:

- | | | |
|---|--|--|
| <input type="checkbox"/> Free Standing Facility | <input type="checkbox"/> Hospital | <input type="checkbox"/> Outpatient Facility |
| <input type="checkbox"/> Inpatient Facility | <input type="checkbox"/> Long Term Care Facility | <input type="checkbox"/> Physician Office |
| <input type="checkbox"/> Mobile Unit | <input type="checkbox"/> Other (specify): _____ | |

2. Is overnight care provided? Yes No

If overnight care is provided, describe staffing levels, qualifications and patient to staff ratio:

3. Is the Applicant involved in any research activities? Yes No

If yes, please use the Comments section to explain.

B. College/University Health Center, Community Health Center, Convenience Care/Retail Clinic, Municipal Health Center, UrgiCenter

1. Does the Applicant provide any of the following services? Please indicate if not applicable: N/A

- | | | |
|--|--|---|
| <input type="checkbox"/> Emergency Care | <input type="checkbox"/> Surgery | <input type="checkbox"/> Obstetrical Deliveries |
| <input type="checkbox"/> X-Ray/Imaging Services | <input type="checkbox"/> Pediatric Primary Health Care | <input type="checkbox"/> Abortions |
| <input type="checkbox"/> Invasive Procedures/Minor Surgery | <input type="checkbox"/> Prenatal Care | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Laboratory | | |

2. Does the Applicant have a referral network for patients who are in need of further treatment? Yes No
3. Does the Applicant provide follow-up patient status calls? Yes No
4. Does the Applicant provide instructions for after-hours care? Yes No
5. Does the Applicant dispense controlled narcotics? Yes No

C. Dialysis Center and Oncology Services

1. What type of facility do you operate: Dialysis Center Oncology Services
2. Are employees properly trained to operate medical equipment? Yes No
3. Is equipment serviced by an in-house employee? Yes No
If yes, is the employee trained to service the equipment? Yes No
4. Is equipment serviced by an outside vendor? Yes No
If yes, does the contract for maintenance include a hold harmless indemnification clause? Yes No
Do you require the vendor to carry professional liability insurance? Yes No
If yes, what minimum limits of liability do you require them to carry? \$ _____
5. Are user manuals available in-house for every piece of medical equipment? Yes No

D. Medi-Spa

1. What types of services are provided?
2. Indicate the type of lasers used, quantity and procedures performed.

Type of Laser	Quantity	Procedures Performed

3. Is the medical director involved in setting protocol? Yes No
4. Does the medical director review patient medical records? Yes No

E. Optical Establishment

1. Does the Applicant prescribe any pharmaceutical agents to patients for the treatment or management of eye disease or disorders? (Do not include pharmaceutical agents used for diagnostic procedures) Yes No
If yes, describe:
2. Are surgical procedures performed? Yes No
If yes, describe:

F. Sleep Lab

1. Do all professionals have a valid CPR certification? Yes No
2. What is the patient to staff ratio? _____
3. How many technicians are certified by the Board of Registered Polysomnographic Technologists? _____
4. Is there a mechanism to visually monitor and record patients during testing? Yes No
5. Do medically unstable patients have a nurse in attendance during the sleep study? Yes No
6. Do pediatric patients and patients who need assistance with daily living activities have a guardian or caregiver in attendance during the sleep study? Yes No
7. Are patients referred by a physician? Yes No
8. Who performs the screening prior to admitting a patient for a sleep study? _____
9. Does the Applicant have written policies and procedures for all technical procedures? Yes No
10. Does the Applicant provide overnight sleep studies? Yes No
If yes, how many beds? _____

G. Weight Loss Center

1. Describe the types of services offered:
2. Are patients examined by a physician prior to starting any diet or exercise program? Yes No
3. Are services provided under the direction of a physician based on physician orders and plan of care? Yes No
4. Is there an exercise facility on site? Yes No
If yes, is it open to the public? Yes No If yes, annual receipts: \$ _____
Please describe the exercise facility in the Comments section including the equipment and classes available.
5. Does the Applicant sell vitamins, food supplements or beverages to patients? Yes No
If yes, please describe in the Comments section including annual gross revenue.
6. Does the Applicant sell weight loss drugs? Yes No
If yes, please describe in the Comments section including type and annual gross revenue.
7. Does the Applicant advocate the use of weight loss drugs? Yes No
If yes, use the Comments section to explain the type of screening performed on patients using drugs, the monitoring of patients and the types of drugs used.

H. Comments

Section and
Question

Comments
