



Telemedicine Application

MEDICAL PROFESSIONAL LIABILITY INSURANCE

Please type or print all answers in ink. Answer all questions that apply or state "not applicable" to those that do not apply. Sign and date by Applicant.

1. Applicant's name and address _____

2. Medical Specialty(ies) for Telemedicine Services

3. Technology used for Telemedicine Services

- Email Telephone _____ Other (Please Describe)
 Video Conferencing (Please identify video software/platform application being utilized):

4. Have you verified your video conferencing application area all HIPPA Compliant? Yes No

5. Who will be providing telemedicine services to your patients?

- Physicians Mid-Level Practitioners (Nurse Practitioners, Physician Assistants)
 _____ Other (Please Describe) _____

6. Are electronic platforms reviewed by an IT person? Yes No

7. Please list all states from which patients receiving Telemedicine Services are located where the patient is based. (Attach additional pages if needed)

	State	Patient Encounters/Week		State	Patient Encounters/Week		State	Patient Encounters/Week
1.			3.			5.		
2.			4.			6.		

8. Will you prescribe medications via email or a website? Yes No

9. If prescribing Schedule II narcotics and stimulants, effective May, 11, 2023, after this time, clinicians must see patients in person first before prescribing Schedule II medication via telehealth. If yes, please confirm and how? (must follow DEA rules) Yes No

10. Please attach a list of all providers and entities on whose behalf you will provide Telemedicine Services.

11. Do you provide follow-up care? Yes No
 If yes, how? _____

12. Are any patients located in a Nursing Home, ALF, Long Term Care Facility? Yes No

13. Are any patients located in a correctional medicine facility? Yes No

14. Do you ever refuse a patient for a Telemedicine visit if you feel it does not qualify as one? If yes, please provide an explanation on how this is handled. Yes No

15. Are you contracted with a 3rd party Imaging Company? Yes No

16. Is the 3rd party contracted with a Correctional Medicine Facility? Yes No



17. Please describe how follow-up care is rendered:

18. Please describe informed consent procedures specific to Telemedicine patients (Attach copy of informed consent Document) _____

19. Please describe the type of incident :tracking/Event Management reporting system do you have in place:

20. Please describe the type of documentation practices that are in place for Telemedicine patients:

21. Please describe the training completed by the Applicant and any other member of the staff who will be providing Telemedicine Services with respect to HIPAA Compliance, Informed Consent, Types of permissible Equipment, Documentation, Confidentiality, as well as use of the software/platform:

22. What type of coordination is in place for sending a patient for testing? _____

23. What type of coordination is in place with local Health Departments should it become necessary to contact them? _____



WARRANTY STATEMENT

I warrant to the company that I understand and accept the notice stated above, and the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy, I authorize the release of claim information from any prior insurer to the Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of the Applicant

Title

Signature of the Applicant

Date

Signing this form does not bind the Applicant or the Company to Complete the Insurance.

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an applicant for insurance of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person.