DOCTORS professional liability

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. Please attach a list of all providers and entities on whose behalf you will provide Telemedicine Services.
10. Do you provide follow-up care? ◉ Yes ◉ No
    If yes, how? _____
11. Are any patients located in a Nursing Home, ALF, Long Term Care Facility? ○ Yes ○ No
12. Are any patients located in a correctional medicine facility? ◉ Yes ◉ No
13. 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
14. Are you contracted with a 3rd party Imaging Company? ○ Yes ○ No
15. Is the 3rd party contracted with a Correctional Medicine Facility? ○ Yes ○ No

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

_____

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

20. 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:

_____

_____

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

_____

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

_____

23. Effective Date: _____

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.