

## CARDIOLOGY SUPPLEMENTAL QUESTIONNAIRE

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Name (please print)

\_\_\_\_\_  
Policy Number (if currently insured with NORCAL)

**Directions:** Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 4.**

### SECTION I NONINVASIVE PROCEDURES

1. Please identify which of the following procedures you perform and provide the estimated number that you perform per year.

If you do not perform any of the procedures listed below, please check here and go to the Invasive Procedures section.

Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Cardiac MRI	
<input type="checkbox"/> Cardioversion	
<input type="checkbox"/> Computerized Axial Tomography	
<input type="checkbox"/> Catheterization – Diagnostic – Right Heart	
<input type="checkbox"/> MUGA Scan	
<input type="checkbox"/> Pacemaker Insertion – Temporary	
<input type="checkbox"/> SPECT Scan	
<input type="checkbox"/> Stress Test – Treadmill	
<input type="checkbox"/> Stress Test – Myocardial Perfusion Imaging	
<input type="checkbox"/> Stress Test – Stress Echo	
<input type="checkbox"/> Transesophageal Echocardiography	
<input type="checkbox"/> Transtelephonic Pacemaker Monitoring	

2. If you perform MUGA scans and/or myocardial perfusion imaging stress tests and you have not completed a fellowship in nuclear medicine, please provide proof of your nuclear cardiac imaging training and describe your experience with nuclear cardiac imaging:

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## SECTION II INVASIVE PROCEDURES

1. Please identify which of the following procedures you perform and provide the estimated number that you perform per year.

If you do not perform any of the procedures listed below, please check here and go to the Interventional Procedures section.

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Angiography – Coronary		<input type="checkbox"/> Electrophysiology Procedures	
<input type="checkbox"/> Angiography – Noncoronary		<input type="checkbox"/> Automatic Implantable Cardioverter – Defibrillator (AICD) Insertion	
<input type="checkbox"/> Catheterization – Diagnostic – Left Heart		<input type="checkbox"/> Cardiac Arrhythmias Regulation – Catheter Ablation	
<input type="checkbox"/> Intravascular Ultrasound (IVUS)		<input type="checkbox"/> Cardiac Resynchronization Therapy	
<input type="checkbox"/> Pacemaker Insertion – Permanent		<input type="checkbox"/> Electromechanical Mapping of Myocardium	
<input type="checkbox"/> Pericardiocentesis – Diagnostic		<input type="checkbox"/> Electrophysiology Studies	
<input type="checkbox"/> Pericardiocentesis – Therapeutic			

2. If you perform electrophysiology procedures and you have not completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association—approved fellowship in clinical cardiac electrophysiology or you are not certified by the American Board of Internal Medicine or American Osteopathic Board of Internal Medicine with a certificate in clinical cardiac electrophysiology, please provide proof of your training for, and describe your experience with, each applicable procedure:

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## SECTION III INTERVENTIONAL PROCEDURES

1. Please identify which of the following procedures you perform and provide the estimated number that you perform per year.

If you do not perform any of the procedures listed below, please check here and go to the Miscellaneous section.

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Alcohol Septal Ablation Therapy		<input type="checkbox"/> Intracoronary Gene Therapy	
<input type="checkbox"/> Angioplasty – Coronary		<input type="checkbox"/> Intravascular Coiling	
<input type="checkbox"/> Angioplasty – Noncoronary or Carotid		<input type="checkbox"/> Percutaneous Laser Revascularization	
<input type="checkbox"/> Atherectomy		<input type="checkbox"/> Rotablation	
<input type="checkbox"/> Atrial Septal Defect and Patent Foramen Ovale Closure		<input type="checkbox"/> Valvuloplasty	
<input type="checkbox"/> Balloon Atrial Septostomy		<input type="checkbox"/> Vascular Stenting	
<input type="checkbox"/> Brachytherapy			

2. If you perform interventional procedures and you have not completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association—approved fellowship in interventional cardiology or you are not certified by the American Board of Internal Medicine or American Osteopathic Board of Internal Medicine with a certificate in interventional cardiology, please provide the following:

- Proof of your training and hospital privileges for each interventional procedure that you are performing
- A description of the proctoring procedure used at the hospital to credential you for the procedures, including the credentials of the proctoring physician
- A description of your experience in performing interventional cardiology procedures

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3. If you perform percutaneous laser revascularization and you completed your cardiology residency or interventional cardiology fellowship, as applicable, before 1998, please provide proof of your training for the procedure and a description of your experience in performing it:

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## SECTION IV MISCELLANEOUS

1. Do you perform any procedure(s) not already specified on this questionnaire?

If **yes**, please identify the procedure(s) and the estimated number of each that you perform per year:

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2. Do you have hospital privileges for each procedure that you perform?  **Yes**  **No**

If **no**, please identify the procedures for which you do not maintain hospital privileges and explain:

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3. Do you perform catheter-based procedures, percutaneous coronary interventions or electrophysiology procedures in a facility or location other than a general acute care hospital or a facility or location that is immediately accessible to a general acute care hospital by gurney?  **Yes**  **No**

If **yes**, please provide the following on a separate piece of paper and attach the following items for each such facility/location:

- The name and address of the location and the type of facility/location (for example, free-standing cardiac catheterization laboratory or office)
- The specific procedures performed, including whether they are diagnostic only and/or therapeutic
- The types of anesthesia/sedation used
- Your patient selection criteria for the procedures performed
- Proof of the facility's/location's accreditation, certification and/or licensure
- The facility's/location's proximity to the nearest general acute care hospital with cardiac surgery services with which it maintains a transfer agreement and/or at which you maintain admitting privileges
- Listing of the facility's/location's imaging systems (for example, television fluoroscopy) and resuscitative/emergency equipment
- The qualifications and experience of the nurses responsible for monitoring patients
- The names of the owners of the facility/location
- An indication of whether or not other physicians utilize the facility/location
- An indication of the type of association (for example, independent contractor) that you maintain with the facility/location and the other physicians who utilize it, if applicable
- Proof of the facility's/location's professional liability insurance if it is not owned by a hospital

## REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (for example, 2 or 3b):

Page Number	Section Number	Question Number	Remarks
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please provide any additional information material to the risk that has not otherwise been addressed in this questionnaire:

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## REPRESENTATIONS AND WARRANTIES

**NOTE: "Warrant" in the following statement is not applicable to Alaska, Arizona or New Mexico health care providers. By statute, Alaska, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.**

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained in this questionnaire.

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Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name