



# URGENT CARE CENTER LOCATION APPLICATION

This is a supplemental application. Please complete a separate application for each facility. If a question does not apply to the facility, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Your signature is required on page 13.

In addition to the completed application, please provide the following items:

- Copies of the facility's letterhead(s) and advertisements
- A list of all procedures performed and services provided in the facility
- **A roster of the individuals who provide services in or on behalf of the facility (refer to Section III for specifics)**

## SECTION I IDENTIFYING INFORMATION

Name of Facility							
Address		City		County		State	Zip Code
Telephone Number		Fax Number			Website Address		
Location Type: <input type="checkbox"/> Freestanding – Hospital Satellite <input type="checkbox"/> Freestanding – Independent <input type="checkbox"/> Hospital-based <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other (specify): _____							
Hours of Operation:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

1. Please describe the ownership of the facility. If there is more than one owner, attach an organizational chart that identifies the facility's ownership structure and each owner's percentage of ownership interest:

\_\_\_\_\_  
\_\_\_\_\_

2. Please describe the facility's scope of practice:

\_\_\_\_\_  
\_\_\_\_\_

3. Please explain how the facility is held out to the public (for example, urgent care facility or extended hours office):

\_\_\_\_\_  
\_\_\_\_\_

4. Are the services provided in the facility limited to a specific physician or medical group?     **Yes**     **No**

**If yes,** please identify the physician or medical group:

\_\_\_\_\_  
\_\_\_\_\_

## SECTION II COVERAGE/INSURANCE INFORMATION

**Facility Requested Effective Date** (the date you wish coverage to begin)

**NOTE: Please complete this question only if this is an application to add a new location to an existing NORCAL policy. NORCAL should receive the application at least thirty days before the Requested Effective Date.**

\_\_\_\_\_ 12:01 a.m. Local Time  
 Month Day Year

### Facility Prior Acts Coverage (check one)

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and the effective date of coverage for this location and 2) arose out of acts or omissions occurring on or after the Policy and location Retroactive Dates and before the termination or Expiration Date of that policy and location. The Retroactive Date is the earliest date on which a medical incident or occurrence may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current carrier, if applicable. This coverage does not apply to the optional Health Care General Liability Insurance. **NORCAL does not automatically provide Prior Acts Coverage.**

The facility wishes to apply for Prior Acts Coverage. Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Tail Coverage from your current carrier. (Please identify the Requested Retroactive Date below and complete the Prior Acts Coverage section on page 12):

The facility does **not** wish to apply for Prior Acts Coverage. It is understood that if the facility does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the effective date of coverage for this location.

### Facility Requested Retroactive Date

\_\_\_\_\_ 12:01 a.m. Local Time  
 Month Day Year

**NOTE:** The Retroactive Date, if specified, must be the same as the Retroactive Date of your current policy.

### Facility Professional Liability Insurance History

**NOTE:** Please complete the questions in this section only if one of the following applies:

- This is an application to add a new location to an existing NORCAL policy and it is not a brand new facility, or
- The facility's professional liability insurance history is different from the organization's professional liability insurance history as indicated on the Health Care Facilities Policy Application

1. Please complete the following regarding all professional liability insurance maintained by the facility during the past ten years, beginning with the most current. Please photocopy this page if additional space is needed.

Name of Insurer	Coverage Dates (month/day/year)	Deductible or Self-insured Retention?	Policy Type	If Claims Made, Check One
	From:  To:	<input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, specify type: _____  Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From:  To:	<input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, specify type: _____  Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____

2. If any one of the insurance coverages identified above was Claims Made Coverage, and the group/organization did not purchase Tail Coverage or Prior Acts Coverage, please explain in the Remarks section on page 12.

### SECTION III HEALTH CARE PROVIDERS

1. Please provide the name and designation of the medical director:

---

---

2. Does the medical director provide professional health care services in the facility in addition to his/her administrative duties?  
 Yes  No

3. Please provide a roster of all individuals who provide services in or on behalf of the facility. The roster must include the following items for each individual:

- Name and designation
- Type of provider (i.e., physician, nurse practitioner, registered nurse, etc.)
- Whether the individual is a partner/shareholder, employee, independent contractor or staff member

4. Does the facility lease any health care personnel from other organizations or individuals (e.g., temporary employment agencies)?  
 Yes  No

If yes, please provide a copy of the contract(s).

5. Are all personnel who provide professional health care services in or on behalf of the facility licensed and/or certified as required by state law for the services they provide?  Yes  No

If no, please explain:

---

---

6. Please answer the following regarding those individuals who render services in or on behalf of the facility but who are **not** employees:

a. Are they required to maintain professional liability insurance with limits of liability of at least \$1 million per claim/\$3 million annual aggregate?  Yes  No

b. Are they required to provide proof of professional liability insurance at least annually?  Yes  No

If you answered no to question 6a or 6b, please explain:

---

---

7. Please check all that apply to individuals who are rendering services in or on behalf of the facility but who are not owners or employees:

Share in the facility's profits and/or overhead expenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use the facility's letterhead?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Use the facility's advertisements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bill under the facility's name?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any one of the above, please identify the name and designation of each individual and the applicable common action(s) pertinent to him or her:

---

---

## SECTION IV ACCREDITATION, CERTIFICATION AND LICENSURE

1. Has the facility ever been denied accreditation, certification and/or licensure, has its accreditation, certification and/or licensure ever been suspended or revoked or has it been subject to probationary terms or conditions?  Yes  No

If yes, please explain and provide a copy of the results of the inspection(s) that led to the denial, suspension or revocation:

---



---

2. Is the facility currently licensed by a state health agency?  Yes  No

If yes, please provide a copy of the license.

3. Is the facility currently accredited?  Yes  No

If yes, please identify each agency and provide proof of accreditation, a copy of the agency's most recent inspection report and the facility's responses to any contingencies and/or deficiencies:

JCAHO  AAAASF  AAAHC  IMQ  Other: \_\_\_\_\_

If no, please indicate if the facility is scheduled for an inspection, and if so, specify with what agency and the date of the inspection:

---



---

## SECTION V SERVICES AND PROCEDURES

1. Please complete the following table regarding the *estimated* number of patient visits in the facility during the current year and the *actual* number of patient visits in the facility during the applicable prior years. Please provide the numbers for each calendar year (January through December).

Current Year Estimate	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year

2. Please identify the type(s) of anesthesia used in the facility. Please use the American Society of Anesthesiologists' current definitions for the levels of sedation/analgesia:

Local/Topical Anesthesia  Regional Anesthesia (excluding spinal/epidural)  Spinal/Epidual  
 Moderate Sedation  Deep Sedation  General Anesthesia

3. What percentage of the clinic's patients are walk-ins requiring urgent or emergency care? \_\_\_\_\_%
4. For what percentage of the patients treated in the facility do facility personnel serve as the primary care provider? \_\_\_\_\_ %
5. What percentage of the patients treated in the facility continue their care with facility personnel following their initial visits? \_\_\_\_\_ %
6. Do facility personnel ever follow patients after they have been admitted into the hospital?  Yes  No

If yes:

- a. Please identify how often this occurs and the nature and scope of the services provided by facility personnel after the patients have been admitted (i.e., attending, assisting in surgery, primary surgeon):

---



---

- b. Is the hospital care provided by facility personnel limited to patients who have been treated in your facility?  Yes  No

If no, please explain:

---



---

7. Do facility personnel perform or provide the following in or on behalf of the facility?

Cosmetic Procedures  Yes  No

Emergency Care  Yes  No

Obstetrical Services (including prenatal care)  Yes  No

If you answered yes to any one of the above, please explain, identify the percentage of the facility's practice devoted to the applicable procedure/service and identify who performs the procedures/provides the services:

---

---

8. Are exercise EKGs performed in the facility?  Yes  No

**If yes:**

a. Is the patient's blood pressure monitored?  Yes  No

b. Is the patient's heart rhythm monitored via an EKG monitor?  Yes  No

If you answered no to question 8a or 8b, please explain:

---

---

9. Does any individual other than a physician, nurse practitioner, physician assistant or registered nurse perform the initial triage and screening of an individual who presents to the facility?  Yes  No

**If yes,** please identify the individual(s), along with his or her designation(s) and qualifications:

---

---

10. Do any nonphysician personnel provide professional health care services in the facility when a physician is not on-site?  Yes  No

**If yes,** please provide the following in the Remarks section on page 12:

- The name and designation of each nonphysician and the type(s) of services provided by him or her when a physician is not on-site
- The type of supervision provided and by whom, and whether a physician is always on call
- If a physician is on call, the maximum amount of time it would take him or her to make it to the facility
- The number of hours per week that the facility does *not* have a physician on-site during its hours of operation

## SECTION VI ANCILLARY SERVICES

1. Does the facility provide any of the following services on-site?

Pharmaceutical  Yes  No    Laboratory  Yes  No    Radiology  Yes  No

**If yes,** please answer the remaining questions in this section.

2. Does the facility maintain separate professional liability insurance for any one of these services?  Yes  No

**If yes,** please identify the service(s) for which the separate professional liability insurance is maintained and provide proof of the insurance:

---

---

3. Are the services provided only for individuals who will undergo surgery or a procedure in the facility?  Yes  No

**If no,** please explain:

---

---

4. If laboratory services are provided on-site, please answer or provide the following:

a. Please identify which one of the following currently applies regarding the facility's CLIA certification:

- Certificate of Compliance                       Certificate of Accreditation                       Certificate of Waiver  
 Certificate for Provider-Performed Microscopy Procedures                       Certificate of Registration  
 No Certificate (please explain): \_\_\_\_\_

b. If the facility has a certificate of registration, when is the facility scheduled to be inspected? \_\_\_\_\_

c. Please provide a copy of the facility's laboratory license.

d. Are the laboratory services provided by the facility limited to those authorized by its CLIA certification?  Yes  No

If no, please explain:

\_\_\_\_\_  
\_\_\_\_\_

5. If radiology services are provided on-site, does any one other than a radiologist interpret the images?  Yes  No

If yes, please indicate who interprets the images, the type(s) of images interpreted by nonradiologists and whether the images are overread by a radiologist:

\_\_\_\_\_  
\_\_\_\_\_

If a radiologist does not overread the images interpreted by a nonradiologist, does the individual who interpreted the image render a formal report?  Yes  No

If no, please explain:

\_\_\_\_\_  
\_\_\_\_\_

## SECTION VII TELEMEDICINE

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine."

1. Does the facility:

a. Provide telemedicine services?  Yes  No

b. Receive telemedicine services?  Yes  No

If you answered yes to either of the above, please explain and provide a copy of the contract(s):

\_\_\_\_\_  
\_\_\_\_\_

## SECTION VIII MISCELLANEOUS

1. Please identify the means used to admit patients into the hospital should the need arise:

- Transfer agreement with hospital       Facility physicians with admitting privileges       Call 911  
 Other (specify): \_\_\_\_\_

If the facility has a transfer agreement with a hospital(s), please identify each hospital and the facility's distance to it (in miles):

---

---

2. What is the maximum response time (in minutes) to the facility for emergency medical services (EMS)? \_\_\_\_\_

3. What is the maximum transport time (in minutes) from the facility to the nearest emergency department? \_\_\_\_\_

4. Please identify if health care providers certified in the following are *always* on-site during the facility's hours of operation:

Basic Life Support?  **Yes**    **No**   Pediatric Basic Life Support?  **Yes**    **No**

Advanced Cardiac Life Support (ACLS)?  **Yes**    **No**   Pediatric Advanced Life Support (PALS)?  **Yes**    **No**

If you answered no to all of the above, please identify the minimum requirements for health care providers:

---

---

5. Does the facility maintain a crash cart that is immediately available to each patient in the facility at all times and that is equipped with at least cardiac drugs (needed to comply with current ACLS standards), basic airway and IV access equipment, a cardiac monitor/defibrillator *and* supplemental oxygen?  **Yes**    **No**

If **no**, please identify the emergency equipment that is available in the facility:

---

---

6. Please identify the percentage of the facility's patients who are pediatric patients: \_\_\_\_\_ %

If pediatric patients are treated in the facility, is the facility equipped with age-appropriate emergency equipment and drugs?

**Yes**    **No**

If **no**, please explain:

---

---

7. Are any drugs, pharmaceuticals, devices or equipment used, administered, distributed or prescribed in or on behalf of the facility that are disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings?

**Yes**    **No**

If **yes**, please explain:

---

---

8. Are all medications stored in a secure location and handled in compliance with federal, state and local laws and regulations?

**Yes**    **No**

9. Does the facility comply with all federal, state and local laws and regulations regarding the disposal of hazardous waste material?

**Yes**    **No**

10. Is all facility equipment (i.e., emergency, etc.) maintained, tested and inspected according to manufacturers' guidelines and federal, state and local laws and regulations?  **Yes**    **No**

If you answered no to any one of questions 8 – 10, please explain:

---

---

## SECTION IX RISK MANAGEMENT

1. Does the facility have a formal risk management program?  Yes  No

a. If yes, who (name and title) is responsible for the risk management program?

---

b. If no, please explain:

---

---

### Credentialing

1. Does the facility have a formal process to credential its health care providers?  Yes  No

a. If yes, please identify who performs the initial credentialing (e.g., employee, hospital, outside company):

---

---

b. If no, please explain:

---

---

2. Does the facility evaluate the following when credentialing its health care providers?

Claim History  Yes  No If yes, source(s) used: \_\_\_\_\_

Hospital Privileges  Yes  No

Employment History  Yes  No If yes, source(s) used: \_\_\_\_\_

Education History  Yes  No If yes, source(s) used: \_\_\_\_\_

Felony/Misdemeanor History  Yes  No If yes, source(s) used: \_\_\_\_\_

Medical/Dental/Nursing and Narcotic Licenses  Yes  No If yes, source(s) used: \_\_\_\_\_

If you answered no to any one of the above, please explain:

---

---

3. Does the facility use the same credentialing procedures to credential independent contractors and locum tenens health care providers?  Yes  No

If no, please describe the credentialing process used:

---

---

4. How often are the facility's health care providers recredentialed?

---

---

## Quality Assurance

1. Does the facility maintain written policies for the handling of emergency situations and are all health care personnel trained on them?  **Yes**  **No**

**If yes:**

- a. Are new employees required to complete this training before being allowed patient contact?  **Yes**  **No**

b. How often is training updated? \_\_\_\_\_

If you answered no to question 1 or 1a, please explain:

---

---

2. Does the facility have a formal process to evaluate and address concerns of unexpected patient outcomes?  **Yes**  **No**

3. Does the facility have a formal process to evaluate patient complaints?  **Yes**  **No**

4. Does the facility conduct patient satisfaction surveys?  **Yes**  **No**

**If yes**, how often: \_\_\_\_\_

## Utilization Review

1. Does the facility have its own utilization review committee?  **Yes**  **No**

**If yes:**

- a. Does the facility have written policies and procedures for appeals of denied procedures?  **Yes**  **No**

b. Who performs the utilization reviews? \_\_\_\_\_

---

- c. Are claim denial procedures explained in writing to patients?  **Yes**  **No**

- d. Does a physician review all proposed denials of benefits?  **Yes**  **No**

- e. Is there a fast track appeal system for denied procedures that may severely impair the quality of life for a patient if not performed?  **Yes**  **No**

## Medical Records

1. Does the facility currently use electronic medical records?  **Yes**  **No**

**If yes:**

a. Who is the vendor? \_\_\_\_\_

b. How often are the electronic files backed up? \_\_\_\_\_

c. Who backs up the files? \_\_\_\_\_

d. Are the backed-up files stored at an off-site location?  **Yes**  **No**

If you answered no to question 1d, please explain:

---

---

e. Are all systems (e.g., inpatient, outpatient, billing, scheduling) electronic?  **Yes**  **No**

If you answered no to question 1e, how are the different systems coordinated?

---

---

2. Do the facility's health care providers create and maintain a medical record for each patient under their care?  **Yes**  **No**

3. Is it a requirement that procedure/treatment notes be dictated/written on the day of the procedure/visit?  **Yes**  **No**

If you answered no to question 2 or 3, please explain:

---

---

4. How are record-keeping deficiencies identified and handled?

---

---

## SECTION X SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (e.g., medical board documents, letters from a hospital, diversion program and/or treating physician, etc.).

1. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the facility?  Yes  No
2. Have the facility's membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending?  Yes  No
3. Has the facility **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?  Yes  No
4. Has the facility or any facility member **ever** been accused of sexual misconduct?  Yes  No
5. Do you know if any individual who works on the facility's behalf has a prior history or propensity for sexual misconduct?  Yes  No

## SECTION XI CLAIMS HISTORY

Other than any claims, incidents, etc. that have already been reported on the organization's main application, if applicable:

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the facility, or has the facility been notified of its involvement in a malpractice claim or suit, either directly or indirectly?  Yes  No
2. Is the facility aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against the facility, directly or indirectly, even if you believe the claim or suit would be without merit?  Yes  No

**If you answered yes to question 1 or 2, please complete a Claim Information Form on page 14 for each applicable claim, suit, incident, conduct, etc.**



## For California and Rhode Island Facilities Only

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 the facility's coverage. I agree to notify NORCAL Mutual Insurance Company immediately if the facility's practice changes in any way and of any change in the information contained on this application.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

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

## For Alaska Facilities Only

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

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Date

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

# CLAIM INFORMATION FORM

Name of Patient: \_\_\_\_\_ Gender:  Male  Female

Age of Patient (at time of treatment): \_\_\_\_\_

Name of Claimant (if different than patient): \_\_\_\_\_

Location of Incident: \_\_\_\_\_

Allegation Against the Facility: \_\_\_\_\_

Facility Member Defendants: \_\_\_\_\_

Non-Facility Member Defendants: \_\_\_\_\_

Date Incident or Claim Was Reported to the Insurance Company: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Disposition or Current Status of the Incident, Claim or Suit Against the Facility:

Open

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

Closed

Date Closed (month/day/year): \_\_\_\_\_

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in the entity's favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): \_\_\_\_\_

Amount paid on the facility's behalf: \_\_\_\_\_

Total verdict amount (if different than total loss payment amount): \_\_\_\_\_

