



EMERGENCY MEDICINE GROUP

LOCATION APPLICATION

This is a supplemental application. Please complete a separate application for each location at which the group's members are rendering services. If a question does not apply, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Your signature is required on page 6.

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

- A copy of the group's contract(s) to provide services at this location
- **A roster of the individuals who provide services on behalf of the group (refer to Section IV for specifics)**

SECTION I IDENTIFYING INFORMATION

Name of Group				
Name of Location				
Address	City	County	State	Zip Code

SECTION II COVERAGE/INSURANCE INFORMATION

Requested Effective Date (the date you wish coverage to begin for the services rendered at this location)

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

Location 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 group wishes to apply for Prior Acts Coverage for the services rendered at this location. 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 5):
- The group does **not** wish to apply for Prior Acts Coverage for the services rendered at this location. It is understood that if the group does not obtain Prior Acts Coverage for the services rendered at this location, 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 the services rendered at this location, if issued.

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.

SECTION III EMERGENCY SERVICES

1. Please identify the type of emergency department:

- Hospital-based Freestanding – Hospital Satellite
 Freestanding – Independent (name of owner): _____
 Other (specify): _____

2. When did the group begin providing services at this emergency department (month/day/year): _____

3. Please identify the levels of emergency care provided (as defined by the JCAHO). Check the highest level applicable:

- Level I (Tertiary) Level II (Comprehensive) Level III (Basic) Level IV (Standby)

4. Is the facility classified as a trauma center? **Yes** **No**

5. Please identify the type of accreditation maintained by the facility in which the emergency department is located:

- JCAHO AOA Other (specify): _____
 Not Accredited (explain): _____

6. If the facility is accredited, were any discrepancies related to the emergency department identified in any inspection within the past 5 years? **Yes** **No**

If yes, please provide a copy of the report, the response(s) to any contingencies and/or deficiencies and the steps taken to correct the discrepancies:

7. Does the group have the exclusive contract to provide the emergency services at this facility? **Yes** **No**

If no, please identify who else contracts with the facility to provide these services and explain how the services are divided between your group and the other group(s):

8. Do any group members serve as the medical director of the emergency department of this facility? **Yes** **No**

If yes, please identify each individual and provide proof that the physician is covered under the facility's policy for these duties, since NORCAL does not provide coverage for these duties:

SECTION IV HEALTH CARE PROVIDERS

1. Please provide a roster of all individuals who provide services on behalf of the group at this location. 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

2. Does the group 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).

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

If **no**, please explain:

4. Please answer the following regarding those individuals who render services in or on behalf of the group 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 4a or 4b, please explain:

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

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

6. What is the *minimum* requirement regarding the training and experience for those physicians who provide emergency care on behalf of the group at this location?

- Completed an ACGME- or AOA-approved postgraduate training program in emergency medicine and/or certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine
- Completed an ACGME- or AOA-approved postgraduate training program in a medical specialty other than emergency medicine *and* certified in Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS) and Pediatric Advanced Life Support (PALS)
- Other (specify): _____

7. If the group utilizes nurse practitioners and/or physician assistants to provide services at this location, please provide the maximum ratio of nurse practitioners and/or physician assistants to physicians rendering services (for example, one nurse practitioner and/or physician assistant to two physicians):

Work Outside of Group Employment

1. Does the group permit its employees to render services unrelated to the group's practice? Yes No

NOTE: The NORCAL policy provides coverage to an Insured only while he or she is acting within the course and scope of his or her duties for the Named Insured.

If yes:

- a. Is the employee required to obtain separate insurance to cover the outside exposure? Yes No
- b. Is the employee required to notify the group of any outside exposure(s)? Yes No

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

SECTION V SERVICES AND PROCEDURES

1. Please complete the following table regarding the *estimated* number of patient visits that will be billed under the following CPT codes during the current year and the *actual* number of patient visits that were billed during the prior year at this location. Please provide the numbers for each calendar year (January through December).

	Current Year Estimate	First Prior Year Actual	Second Prior Year Actual	Third Prior Year Actual	Fourth Prior Year Actual	Fifth Prior Year Actual
99281						
99282						
99283						
99284						
99285						
Other						

2. If you indicated patient visits for "other", please explain:

SECTION VI MISCELLANEOUS

1. Does the group own or operate an ambulance service at this location? Yes No

If yes:

- a. Please identify the location(s) serviced by it:

- b. Does the group maintain separate professional liability insurance for the ambulance service? Yes No

If yes, please identify the insurance carrier and the limits of liability of the policy:

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

Signature of Authorized Representative

Date

Print Name