Healthcare Facility Bariatric Supplemental Application

ProAssurance
Treated Fairly

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

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Legal Entity Name: _____

_____

Address: _____

_____

City, State, ZIP: _____

1. Is this facility designated as a Center of Excellence in Bariatrics? ☐ Yes ☐ No
2. Types of open bariatric surgeries:
   a. Gastrointestinal procedures ☐
   b. Biliary surgery procedures ☐
   c. Vertical banded gastroplasty ☐
   d. Roux-en-Y gastric bypass ☐
   e. Extensive gastric bypass (Biliopancreatic diversion) ☐
   f. Other: _____ ☐
3. Types of Laparoscopic bariatric surgeries:
   a. Lap banded ☐
   b. Lap stapled ☐
   c. Lap Roux-en-Y ☐
   d. Other: _____ ☐
4. Is staff credentialed for bariatric procedures? ☐ Yes ☐ No
5. Does the facility require and utilize a multidisciplinary team including surgeon, anesthesiologist, psychiatrist, eating disorder specialist, internist, cardiologist, dietician, exercise physiologist, etc. for each patient? ☐ Yes ☐ No
6. Is the facility properly equipped to accommodate severely obese patients (chairs, beds, scales, lifts, operating room equipment, bariatric instruments, commodes, wheelchairs, radiology and other diagnostic equipment)? ☐ Yes ☐ No
7. Are there established fall and emergency procedures in place? ☐ Yes ☐ No
8. Are there established follow up and call back procedures in place? ☐ Yes ☐ No
9. Is proper patient selection criteria utilized and documented? ☐ Yes ☐ No
10. Is proper informed consent executed and documented? ☐ Yes ☐ No
11. Please provide a contact name and phone number to schedule a risk management survey.

_____ Contact Name

_____ Phone

12. Provide marketing/advertising materials (i.e. newspaper and magazines, brochures, emails, website, etc.).

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Name: _____ Title: _____

Signature: _____ Date: _____

Insurance Agent/Broker (if applicable):			
Agent:		Phone:	
Agency:		Fax:	
Address:		Email:	
		License No.:	
Signature:			

HEALTH CARE FACILITY APPLICATION ADDENDUM

PCF SCHEDULE OF ENTITIES AND D/B/A'S

NOTE: In compliance with the Indiana Patient Compensation Fund Guidelines all eligible entities and business names (D/B/A's) operating under the hospital's license must be scheduled on the Patient Compensation Fund Certificate, and remit the applicable surcharge to be extended coverage by the Patient Compensation Fund. Rating exposures (including but not limited to outpatient visits, one day surgery procedures, home health visits, inpatient days, etc.) of scheduled entities and operations are to be included on the Health Care Facility Application.

Other hospital owned or controlled eligible entities and D/B/A's operating under separate licensure must make separate PCF application, pay applicable surcharge, and meet underlying primary coverage requirements. Failure of the hospital to comply with PCF requirements could result in a declination of coverage by the Patient Compensation Fund.

Name:	**Tax ID #**	**Health Dept License #**