Print Form Clear Form Save

Healthcare Facility Application
Surgery Center—Renewal

ProAssurance. Treated Fairly

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

Expiring Policy No. _____

1. Introductory Information

Policyholder Name: _____

Address: _____

City: _____ County: _____ State: _____ ZIP: _____

Telephone Number: _____ Fax Number: _____

Fiscal Year Begins: _____

Contact Name: _____ Contact Email: _____

Website Address: _____

Instructions:

1. Please review and complete this renewal application.
2. When necessary, check all boxes that apply.
3. If you need more space for your responses, continue on a separate sheet indicating question number.

2. General Information

A. Has there been a change in facility ownership or management? ☐ Yes ☐ No
If *yes*, please explain: _____

B. Provide details of any new start-up services or any services discontinued during the past fiscal year.

C. Has the facility's license been revoked, suspended or restricted during the past fiscal year?
If *yes*, please provide details: _____

D. Has any accreditation program revoked, suspended or restricted the facility's accreditation status?
If *yes*, please provide details: _____

E. Please provide a copy of the facility's latest fiscal year-end audited financial statement.

F. Please provide an updated schedule of locations and insured entities.

3. General Exposure Data

A. Are anesthesia services provided by:
☐ Employed physicians ☐ Contract group ☐ Employed CRNA's

i. If under contract, name of group: _____

ii. If contract group, are certificates of insurance required? ☐ Yes ☐ No
If *yes*, what minimum limits are required: _____ per claim _____ aggregate

B. Is Limited Pollution Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

C. Is Excess/Umbrella Liability coverage desired? If *yes*, separate application required. ☐ Yes ☐ No

D. Do you maintain any beds for overnight occupancy? ☐ Yes ☐ No

Surgery Center: _____ No. Operating Rooms Hours of Operation: _____

_____ No. Occupied overnight/24-hour Beds

E. Facility is licensed as: ☐ Ambulatory Surgical Center ☐ Surgical Hospital

F. Select each type of surgical service that applies and provide the number of annual procedures.

Type of Procedure	Annual No. Procedures for Last Fiscal Year	Type of Procedure	Annual No. Procedures for Last Fiscal Year
*Bariatric		Gastroenterology	
Obstetrics		Vascular	
Urology		Cardiac Catheterization	
Hand		Otolaryngology (ENT)	
Orthopedic		Thoracic	
Colon and Rectal		Plastic (reconstructive)	
Head and Neck		Endoscopy	
General		Pain Management	
Cosmetic		Gynecology	
Podiatry		Oral and Maxillofacial	
Neurology		Wound Care	
Ophthalmology (cataracts)		Other (describe):	
Ophthalmology (Lasik, PRK, TKP)			

**Separate Application Required if new operation – Refer to Company*

G. Other services provided:

Medical Lab _____ Annual Receipts X-ray/Imaging Center _____ Annual Receipts

4. Personnel

A. Physicians providing health care services at this entity:

Name	Specialty	Board Certified	Limits	C=Contracted E=Employed O=Owner	Current Insurance Carrier

Please attach additional sheets if necessary.

B. Do you require certification of Professional Liability Coverage? ☐ Yes ☐ No

If *yes*, how much? _____

C. **Non-Physician Personnel**

	No. Employed	No. Contracted
Aids or Orderlies		
Anesthesiology Assistant		
*Dentists		
EEG or EKG Operators		
Inhalation/Respiratory Therapists		
Laboratory Technicians		
LPNs		
Medical Technicians		
#Nurse Anesthetists - Are they supervised by an anesthesiologist? ☐ Yes ☐ No		
#Nurse Practitioners		
Occupational/Physical Therapists		
Paramedics or EMTs		
Pharmacists		
#Physician Assistants		
*Podiatrists		
RNs		
Scrub Nurses		
#Surgical Assistants		
X-ray or Radiology Technicians		
X-ray or Radiology Therapists		
Other (describe):		

**Separate Application Required – Refer to Company*
#Separate Application Required for New Personnel if not Previously Submitted

5. Premises and Operations

A. Are there any construction plans for the next twelve months? ☐ Yes ☐ No
If *yes*, please provide cost of project: _____

B. Total square footage of parking lots or decks: _____

C. Total number of swimming pools: _____

D. Total number of lakes: _____

E. Total number of fountains: _____

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:			

Insured Entities and D/B/A's
Schedule A

Entity Name: ____________________
Address: ____________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ____________________
____
Description of all operations and activities: ____________________
____

Entity Name: ____________________
Address: ____________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ____________________
____
Description of all operations and activities: ____________________
____

Entity Name: ____________________
Address: ____________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ____________________
____
Description of all operations and activities: ____________________
____

Entity Name: ____________________
Address: ____________________
____
Tax ID No.: ____________________ Retroactive Date: ____________
Ownership and relationship to the policyholder: ____________________
____
Description of all operations and activities: ____________________
____

Please attach additional sheets if necessary.

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 #**