



P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

## AMBULATORY SURGERY CENTER RENEWAL APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the expiring effective date of coverage.
- If a question is not applicable, then state "N/A".

### GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) \_\_\_\_\_

2. Indicate change(s) in general information below. Check here if **NO** change(s) in general information from last year:

3. Mailing / Location Address(es):

(1) \_\_\_\_\_  
STREET CITY COUNTY STATE ZIP

(2) \_\_\_\_\_  
STREET CITY COUNTY STATE ZIP

Attach Additional Pages as Needed

4. Provide any other general information change(s) below:  
\_\_\_\_\_  
\_\_\_\_\_

5. Inspection/Risk Management Contact Name: \_\_\_\_\_

6. Inspection/Risk Management Contact E-mail: \_\_\_\_\_

### APPLICANT'S PRACTICE

7. Is the applicant accredited by or a member of any professional organization or association? Yes  No   
If yes, please name: \_\_\_\_\_

8. Estimated annual gross revenues in the next 12 months? \$ \_\_\_\_\_

Annual gross revenues in the past 12 months? \$ \_\_\_\_\_

9. Does applicant maintain beds for overnight occupancy? Yes  No   
 If yes, how many? \_\_\_\_\_ Also attach a copy of license and an explanation including protocols for onsite 24 hour staffing.

10. Please provide number of procedures / services for the following:

TYPE OF PROCEDURE	NUMBER PAST 12 MONTHS	ESTIMATED NUMBER NEXT 12 MONTHS
Abortions		
Bariatric Surgery - <i>List Procedures Below</i>		
Cosmetic Surgery		
Dental/ Oral Surgery		
Endoscopy/ Colonoscopy		
General Surgery		
Gynecological Surgery		
Manipulation under Anesthesia		
Obstetric		
Ophthalmology - Cataract		
Ophthalmology – Lasik / Refractive		
Orthopedic Surgery		
Orthopedic Surgery – Including Spine		
Otorhinolaryngology with Plastic		
Otorhinolaryngology no Plastic		
Pain Management – <i>List Procedures Below</i>		
Plastic/ Reconstructive Surgery		
Podiatry		
Radiological/ Nuclear/ Chemotherapy		
Other: (describe)		
Other: (describe)		
Other: (describe)		

11. **IF BARIATRIC SURGERY OR PAIN MANAGEMENT** is indicated please complete the following
- Please list ALL bariatric or pain management procedures and **attach** protocols for selecting and monitoring patients.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  - Is Bariatric surgery **only** performed by American Board Certified General Surgeons? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure  
 Yes  No  N/A
  - Is this center a Bariatric Surgery Center of Excellence?  
 Yes  No  N/A

**STAFF / CREDENTIALLED PROVIDERS**

12. Please complete the staff / credentialed provider table below **AND** provide a staff listing by name for all credentialed physicians.

	<u>Number Employed?</u>		<u>Number Privileged</u>		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Physicians: no surgery other than incision of boils and superficial abscesses; suturing of skin or superficial fascia					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anesthesiologists; Pain Management Specialists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dermatologist; Cardiologists; Gastroenterologist; Proctologists; Ophthalmologists; Urologists, Internists;					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
General Surgeons; Cardiac Surgeons;					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Thoracic Surgeons; Vascular Surgeons; Neurosurgeons; and Orthopedic Surgeons					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bariatric Surgeons					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Podiatrists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dentists; Oral Surgeons					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nurse Anesthetists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physicians' and Surgeons' Assistants; Nurse Practitioners					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Perfusionists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pharmacists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chiropractors					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
RNs, LPNs					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
X-Ray Technician; Lab Technician					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other (specify):						



**NOTICE TO FLORIDA APPLICANTS:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**NOTICE TO HAWAII APPLICANTS:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NOTICE TO MAINE APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

**NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NOTICE TO NEW MEXICO APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**NOTICE TO NEW YORK APPLICANTS:** Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

**NOTICE TO TENNESSEE APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NOTICE TO VIRGINIA APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.**

**The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.**

Applicant: \_\_\_\_\_ Title: \_\_\_\_\_

FEIN #: \_\_\_\_\_

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent/Broker Name: \_\_\_\_\_

**SUPPLEMENTAL CLAIM / INCIDENT INFORMATION**

If reporting more than one claim or incident, please photocopy and complete a separate form for each. **Attach additional sheets if necessary for adequate explanation.** All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Incident  Claim

Date reported to insurance company: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Date of incident and your treatment: \_\_\_\_\_

Allegations / Circumstances: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Defendants: \_\_\_\_\_

What is the present condition of the patient? \_\_\_\_\_

\_\_\_\_\_

**STATUS OF CLAIM**

- Suit threatened, no action taken
- Suit filed but dropped by claimant
- Summary judgment in your favor

**Court outcome in YOUR favor:**

- Jury verdict
- Directed verdict

**Unresolved/Open**

- Awaiting mediation
- Awaiting court action

Reserve amount:  
\$ \_\_\_\_\_

- Suit settled out of court
  - a. Date claim paid: \_\_\_\_\_
  - b. Amount paid: \$ \_\_\_\_\_
  - c. Did you want to settle?
    - Yes
    - No

**Court outcome in favor of plaintiff:**

- Jury verdict
  - Directed verdict
- Amount of loss payment:  
\$ \_\_\_\_\_

Name and address of the attorney assigned to your case: \_\_\_\_\_

\_\_\_\_\_

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes:  No:

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_