Professional SOLUTIONS | INSURANCE COMPANY

Physician Telemedicine/Telehealth Supplemental Application

A. APPLICANT INFORMATION

Name: ____
First Name Middle Last Name

Name of Employer: ____

PSIC policy number (If applicable): ____

B. TELEMEDICINE/TELEHEALTH INFORMATION

Please indicate the percentage of your practice that is related to Telemedicine/Telehealth: _________%

For the purposes of this supplemental application, Telemedicine/Telehealth is defined as the practice of medicine, or exchange of medical information, using technology and electronic devices for communicating and exchanging information between a provider in one location and a patient in another location with or without an intervening healthcare provider in the efforts to improve, maintain or assist patients' health status. Videoconferencing, the transmission of still images and e-health patient portals and remote monitoring of vital signs are recognized as telemedicine/telehealth.

Please explain any "no" responses using the last page of this application.

1. Please indicate the states in which you treat patients and the percentage from each state:

AL ________ %	IN ________ %	NE ________ %	SC ________ %
AK ________ %	IA ________ %	NV ________ %	SD ________ %
AZ ________ %	KS ________ %	NH ________ %	TN ________ %
AR ________ %	KY ________ %	NJ ________ %	TX ________ %
CA ________ %	LA ________ %	NM ________ %	VT ________ %
CO ________ %	ME ________ %	NY ________ %	VA ________ %
CT ________ %	MD ________ %	NC ________ %	WA ________ %
DE ________ %	MA ________ %	ND ________ %	WV ________ %
FL ________ %	MI ________ %	OH ________ %	WI ________ %
GA ________ %	MN ________ %	OK ________ %	WY ________ %
HI ________ %	MS ________ %	OR ________ %	
ID ________ %	MO ________ %	PA ________ %	
IL ________ %	MT ________ %	RI ________ %	

2. Do you treat patients who reside outside of the United States? .... ❑Yes ❑No
   If yes, please list the countries and the percentage related to your practice's international exposure:
   Countries: ____
   Percentage of exposure: ____
3. Do you have an active medical license and recognition for telemedicine activities (where applicable) in each state where your patients reside? .... ❑Yes ❑No

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B. TELEMEDICINE/TELEHEALTH INFORMATION (continued)

4. Will you deliver care through an "e-visit" using a webcam or "store and forward" format? ❑Yes ❑No
   If yes, please indicate the method and percentage:
   Webcam: ________________ %
   Store and forward: ________________ %
   Remote monitorng: ________________ %
5. Do you follow federal, state and local regulations regarding remote prescribing or dispensing of pharmaceuticals? ❑Yes ❑No
6. Do you use a qualified non-physician provider to assist in each patient encounter? ❑Yes ❑No
   If no, who handles, schedules, prepares and monitors the encounter for quality and safety? ________________
7. Has your staff been educated as to scope of services to be provided? ❑Yes ❑No
   Please provide a list of those services: ________________
8. Is your staff familiar with the system and protocols surrounding telemedicine/telehealth? ❑Yes ❑No
   Please provide a list of your protocols: ________________
9. Do you have a technology interruption plan for handling outages/power loss? ❑Yes ❑No
   How will data be confirmed or recaptured? ________________
   How will appointments be rescheduled? ________________
10. Do you have equipment and maintenance protocols in place with your vendors? ❑Yes ❑No
11. Do you have business associates agreements in place? ❑Yes ❑No
12. Do you have protocols in place to recognize and document when a provider-patient relationship has been established? ❑Yes ❑No
    How and when is the patient informed of the relationship? ________________
13. Do you review and document the patient's medical history? ❑Yes ❑No
    Does the review of the history include medications? ❑Yes ❑No
14. Does the physical exam and review of the patient's medical history support the diagnosis and treatment recommendations provided? ❑Yes ❑No
15. Do you have a policy specifically stating that treatment, including the issuing of a prescription, is prohibited based solely on an online questionnaire? ❑Yes ❑No
16. Do you use an informed consent specifically for the telemedicine encounter? ❑Yes ❑No
    Does your informed consent include:
    - Confirmation of the identification of the patient, the physician and the physician's credentials? ❑Yes ❑No
    - Types of communications permitted using telemedicine technology? ❑Yes ❑No
    - An agreement between the physician and the patient that the condition being diagnosed and/or treated is appropriate for a telemedicine encounter? ❑Yes ❑No
    - Details with regard to patient confidentiality/security measures to protect the patient's personal health information (PHI)? ❑Yes ❑No
    - A hold harmless clause for information lost due to technical failure? ❑Yes ❑No
    - Release of PHI to a third party if and when necessary for continuity of care? ❑Yes ❑No
17. Have practice policies and protocols been established which provide a means of:
    - Recognizing and reducing potential HIPAA and PHI exposures? ❑Yes ❑No
    - Maintaining and documenting of e-visit records for continuity of care? ❑Yes ❑No
    - Recognizing and handling the risks of incomplete or failed transmissions, corrupted files, data breaches or any disruption of technology service situations which could affect the e-visit? ❑Yes ❑No

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B. TELEMEDICINE/TELEHEALTH INFORMATION (continued)

Identifying when face-to-face visits may be necessary? ❑Yes ❑No

Securing an acknowledgment by the patient of appropriate use, response times, rescheduling of e-visits, prescription refills and/or other communications via technology? ❑Yes ❑No

Initiating an emergency plan when a telemedicine visit indicates referral to an acute care facility or ER is necessary? ❑Yes ❑No

C. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent

For residents of all states except Oklahoma:
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 or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

________________________________ ________________________________
Signature of Applicant Date

________________________________ ________________________________
Signature of Agent Date

Mail to:
14001 University Avenue
Clive, Iowa 50325-8258
Email: submissions@psicinsurance.com

Questions:
Phone: 800-788-8540
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