



**SUPPLEMENTAL APPLICATION
DIALYSIS CENTERS**

(Please note that this Supplemental Application must be completed for each facility/location. The Medical Facilities Professional Liability Coverage Application must be completed and submitted with all Supplemental Applications).

NAME OF FACILITY: _____

ADDRESS: _____

I. LICENSING:

A. Is the applicant licensed to do business in the states where required? Yes No

B. If YES, please provide: Yes No

1. Name on License: _____

2. Licensed by state of: _____

3. License # _____

4. Expiration Date: _____

Please provide copy of the current license with this application

C. Has license ever been revoked, suspended, placed on probation or restricted in anyway? Yes No

If YES, please explain: _____

II. GENERAL INFORMATION:

A. Is facility certified for Medicare/Medicaid? Yes No

If YES, please list your Provider Numbers: Medicare _____

Medicaid _____

B. Are you accredited by any organizations? Yes No

If yes, by whom: _____

C. Is the facility affiliated with any correctional or penal facilities? Yes No

III. PATIENT TREATMENT INFORMATION:

A. Are off-premises services provided? Yes No

If YES, please give complete details: _____

B. Is a supervising physician on premises at the time of all hemodialysis treatments at the facility? Yes No

If NO, please explain: _____

C. As respects the dialysis machine(s):

1. Does the facility service its own machines? Yes No

2. Is the facility an Additional Insured under the manufacturers or distributors products liability coverage? Yes No

If the answer to 2. is YES, please identify (i) the Named Insured under such policy, (ii) the insurance company, (iii) the limits of liability, and (iv) whether coverage is claims made or occurrence: _____

D. Is treatment initiated only under a physician's work orders? Yes No

E. Is medication or drugs given:

1. Only under a physician's written orders? Yes No

2. Only by authorized medical professionals? Yes No

If the answer to 1. or 2. above is NO, please explain: _____

F. The number of treatments for each of the past three years was:

200__ _____ 200__ _____ 200__ _____

IV. EMERGENCY & SAFETY PROCEDURES:

A. How often are fire drills conducted? _____

B. How are medical emergencies handled?

1. On Call Physicians? Yes No

2. Affiliated Physicians on Premises? Yes No

3. Hospital and/or emergency center? Yes No

If YES, is hospital and/or emergency center located within a 15 minute drive under typical conditions?

4. Other? Yes No

(explain) _____

C. Specify arrangements for storage and dispensing of drugs: _____

V. STATE INSPECTION

A. Date of last State Inspection/Survey (if applicable): _____

B. Total # of Deficiencies: _____

C. Corrective Action Plan Accepted by State Yes No

Date Accepted: _____

D. Number of Complaints investigated by State the past 2 years : _____

E. Number of Substantiated complaints: _____

VI. PHYSICIAN INFORMATION

A. Please identify by name and function served, all physicians including (psychiatrists, osteopaths, dentists or chiropractors) employed or affiliated with the facility:

Name	Type of Doctor	Specific Duties in Facility Operations

B. Is your facility insured under the Professional Liability issued to each person specified above?

Yes No

Certificates of insurance for doctors will be required, so please state:

Name of Doctor	Insurance Carrier	Insurance Limit	Expiration date of Coverage

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. These medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

I **DECLARE** that the information contained in this supplement is true and that no material facts have been suppressed or misstated.

I **UNDERSTAND** that an incorrect or incomplete response could void my coverage.

Signature of Applicant

Date