TELEMEDICINE QUESTIONNAIRE FOR PROFESSIONAL LIABILITY COVERAGE

Please return the questionnaire within 14 days **Policy Number:** _____

First name: _____ Middle name: _____ Last name: _____

Designation: _____ ☐ Male ☐ Female License # and State: _____

Professional email address: _____Office phone: _____

1. Briefly describe your telemedicine practice and the service you offer to your patients.

   _____

   _____

   _____

2. What is your sub-specialty, if any? _____

3. Do you perform Interventional Radiology? ☐ Yes ☐ No

4. What percentage of your medical practice is dedicated to telemedicine? _____%

5. What percentage of your telemedicine care involves nursing homes, residential facilities, long term care, and/or behavioural health? _____%

6. What percentage of your telemedicine work involves care in emergency situations? _____%

7. Do you practice telemedicine from a state outside the primary location as shown on your application/policy? ☐ Yes ☐ No
   If yes, please provide the name of the state(s): _____

8. Do you practice telemedicine for patients in states outside the primary location as shown on your application/policy? ☐ Yes ☐ No
   If yes, please provide the name of the state(s): _____

9. Does your practice comply with all state requirements for telemedicine and corresponding jurisdictional requirement in **each state** where you practice? ☐ Yes ☐ No

10. Do you meet the medical licensing requirements in **each state** where you practice telemedicine and those in states where your patients reside? ☐ Yes ☐ No

11. Does your office have written policies & procedures in place for telemedicine care? ☐ Yes ☐ No

12. Do you have the necessary infrastructure and equipment to provide telemedicine care? ☐ Yes ☐ No

13. Is your telemedicine work providing care to services outside your Residency/Fellowship training? ☐ Yes ☐ No

14. Are written protocols in place for telemedicine patients who need emergency care? ☐ Yes ☐ No

15. Does your practice follow up to confirm receipt of ordered labs and consults provided via telemedicine? ☐ Yes ☐ No

16. If you utilize a third-party host facility, are protocols in place to ensure timely and adequate reporting of reviews? ☐ Yes ☐ No

17. Do you provide the official report directly to the ordering physician? ☐ Yes ☐ No

18. Are all telemedicine visits captured in your EHR? ☐ Yes ☐ No

19. Do you have a contract with a telemedicine organization to provide patient care? ☐ Yes ☐ No
    If yes, with whom? _____
    Do they provide coverage for your work? ☐ Yes ☐ No

20. Do you delegate authority to others outside your practice to treat patients via telemedicine? ☐ Yes ☐ No
    If yes, how many others outside of your practice are authorized? _____

21. Do you provide telemedicine care to incarcerated patients? ☐ Yes ☐ No

22. Do you monitor electronic Intensive Care Units (eICUs)? ☐ Yes ☐ No
    If yes, how many at one time? _____
    Do you obtain and adhere to the procedure/protocol information from the host facility? ☐ Yes ☐ No

23. Do you perform telesurgery or proctor surgical procedures performed on patients' location at a remote site? ☐ Yes ☐ No

I hereby warrant and represent that the foregoing information is true and correct. I understand and agree that this questionnaire and the statements therein become a part of the policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this questionnaire contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage.

Signature: _____

Printed Name: _____ Date Signed: _____