



## DIAGNOSTIC/IMAGING SUPPLEMENTAL APPLICATION

This application must be completed in conjunction with  
the CNA Allied Health Care Facilities Common Application.

**Instructions:**

1. Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. **Name of Applicant:** \_\_\_\_\_

2. **Risk Management Contact:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

3. **Type of Services (Identify "Annual Gross" receipts for those services that apply:**

Services	Therapeutic Annual Gross Receipts	Diagnostic Annual Gross Receipts
Angiography	\$	\$
Bone Densitometry	\$	\$
CT, Computerized Tomography	\$	\$
EKG and EEG	\$	\$
ESI, Electron Microscopic Imaging	\$	\$
Fluoroscopy	\$	\$
Gamma Camera	\$	\$
Mammography	\$	\$
MRI, Magnetic Resonance Imaging	\$	\$
Interventional Radiology	\$	\$
Nuclear Medicine * (see footnote below)	\$	\$
Particle Accelerators	\$	\$
PET, Position Emission Tomography	\$	\$
Radiation Therapy * (see footnote below)	\$	\$
Ultrasound, Sonography	\$	\$
Stress Tests, Nuclear Cardiac	\$	\$
Terahertz Radiation	\$	\$
*Therapeutic Radiology, Cobalt(see footnote)	\$	\$
X-Ray, General Radiography	\$	\$
Other (describe):	\$	\$
Other (describe):	\$	\$

\* If Nuclear Medicine or Radiation Therapy applies, complete a Cancer Treatment Supplemental Application.

**4. Who does the first read of the diagnostic/imaging test results?**

- applicant's employed or contracted radiologist
- patient's personal physician

**5. Who is responsible to provide the diagnostic/imaging test results to the patient?**

- applicant's employed or contracted radiologist
- patient's personal physician

**6. Applicant invoice/billing of patients. Check all that apply. Indicate percent of revenues.**

- Procedure \_\_\_\_\_% of revenue       Interpretation/reading of test results \_\_\_\_\_% of revenue
- Neither

**7. Applicant invoice/billing of other healthcare providers/payers. Check all that apply. Indicate percent of revenues.**

- Procedure \_\_\_\_\_% of revenue       Interpretation/reading of test results \_\_\_\_\_% of revenue
- Neither

**8. Diagnostic/Imaging equipment maintained**  by an outside party  by the applicant

**9. Contrast Media**

a. If the applicant is injecting contrast media, complete the following:

- Ionic \_\_\_\_\_% of use       Non-ionic \_\_\_\_\_% of use       Los osmolar \_\_\_\_\_% of use

b. Are there protocols for use of contrast media?

- Ionic       yes  no  NA
- Non-Ionic       yes  no  NA
- Los osmolar       yes  no  NA

c. If the applicant is injecting contrast media, is a physician present during the procedure?       Yes  No

**10. Screening Mammography**

a. Is a computer-aided system used to bring suspicious areas on a mammogram to the radiologist's attention?

- Yes  No.

b. Does a second radiologist review all mammography images?

- Yes  No

c. Does the organization have digital mammography capabilities?

- Yes  No

**11. Accreditations/Licensure/Certifications – Provide a copy of the most recent federal/state inspection and accreditations.**

a. Has the applicant received any FDA warning letters?

- Yes  No.

If "yes", submit a copy with this application.

b. If the applicant provides mammography services is the facility FDA certified?

- Yes  No.

c. List certifications and accreditations held by the organization/entity to be insured: \_\_\_\_\_

**12. Quality Improvement/Peer Review**

a. Is there an external peer review program for high risk/high volume studies/images?

- Yes  No.

If "no", describe peer review process: \_\_\_\_\_

b. Does the facility provide:       initial read       over-read/second reads       external peer review services?



**13. Staffing**

- a. List qualifications of the physician who oversees invasive procedures: \_\_\_\_\_
- b. Do technicians/technologists hold specialized certificates?  Yes  No  
If "yes", list the certificates held: \_\_\_\_\_
- c. Are any technicians "grandfathered" or do they hold limited permits?  Yes  No
- d. List qualifications of radiation safety officer: \_\_\_\_\_

- 14. Does the applicant transport any diagnostic/radiology equipment?**  Yes  No  
If "yes", what percentage of service overall does mobile radiology represent? \_\_\_\_\_%

**15. Emergency Equipment**

- a. Is emergency equipment and medications available?  Yes  No.
- b. Are there mock codes?  Yes  No.
- c. Is the staff CPR trained?  Yes  No.

**16. Does the applicant provide Teleradiology Services?**  Yes  No

- a. If "yes", is the "reading" physician licensed in all states in the service area?  Yes  No.
- b. Does the reading physician reside outside of the U.S. and its territories?  Yes  No.

**17. Has the applicant implemented a digital PAC radiology system?**  Yes  No

---

**AUTHORIZATION**

---

**Signature in full** **Date**

---

**Name - please print**

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

**This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation**