



**AMBULATORY SURGERY CENTERS RENEWAL APPLICATION**

**Instructions:**

1. Review your application completed last year in conjunction with this renewal application.
2. 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.
3. This application must be completed, signed and dated by an authorized officer of the entity.
4. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. Name of Applicant: \_\_\_\_\_  
 (Provide names of all legal entities past and present that are intended for coverage. This would include any additional entities acquired this past year).

2. Do you want to change your current insurance structure?  Yes  No
3. Has the applicant had any change to their business operations over the past 12 months?  Yes  No  
 If "Yes" have the exposures and losses been included with this application?  Yes  No
4. Are there any plans to acquire other facilities within the next 12 months?  Yes  No

**If the answer is yes to any of the above provide details on a separate sheet of your letterhead.**

5. Is the applicant Accredited?  Yes  No.  
 If Yes, by whom? \_\_\_\_\_

6. What surgical and medical specialties are provided at the facility(s)?

Services	%	# of Patients Annual Projection
Birthing Centers		
Cardiac catheterization		
Cosmetic		
Endoscopy		
Gastroenterology		
General		
Imaging - venography, fluoroscopy, & ultrasonic needle guidance		
Imaging - noninvasive		
In vitro fertilization		
Lithotripsy		
Ophthalmology/Laser eye		
Ophthalmology/Cataracts		
Oral and maxillofacial		



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Services (continued)	%	# of Patients Annual Projection
Orthopedic		
Pain management		
Plastic surgery		
Podiatry		
Radiation oncology/therapy		
Weight reduction		
Laparoscopic – describe types		
Laser procedures – describe types		
Multi-surgery centers – describe types		
Other – describe types		

Overnight recovery beds	%	# of Patients
23 hours or less – if so how many beds? _____		
24 hours or more – if so, how many beds? _____		

If overnight beds were listed, describe staffing levels, qualifications and patient/staff ratio. \_\_\_\_\_

**7. Ancillary Services**

- a. Do you perform laboratory services for your clients?  Yes  No If yes, revenue \_\_\_\_\_
- b. Do you perform imaging services for your clients?  Yes  No If yes, revenue \_\_\_\_\_

**8. Anesthesia Delivery/Monitoring**

Has the applicant changed the level of anesthesia administrated at the facility?  Yes  No  
If yes, please explain \_\_\_\_\_

**9. Credentialing & Privileging**

- a. Does the applicant continue to have a formal credentialing program?  Yes  No

**10. Medical Staff**

- a. Has there been any review by a state medical board or other federal, state, or non-governmental oversight entity of any physician/practitioner with privileges at the organization?  Yes  No
- b. Has there been any physician/practitioner with privileges in your organization, whose license has been suspended, revoked or voluntarily surrendered?  Yes  No
- c. Any physician/practitioner with privileges in your organization, whose DEA license has been suspended, revoked or voluntarily surrendered?  Yes  No
- d. Have any limitations or conditions been implemented on any physician / practitioner's privileges?  Yes  No
- e. Have any federal or state civil or criminal investigations or actions been initiated or filed that directly or indirectly involve the organization and/or the physicians/practitioners with privileges at the organization?  Yes  No



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- f. Have the organization or any of its officers, administrators, or staff been sanctioned or had disciplinary actions brought against them by federal or state authorities, any professional medical society, accreditation agency or other governmental or non-governmental oversight entity?  Yes  No

IF "YES" RESPONSE TO ANY OF THE ABOVE MEDICAL STAFF QUESTIONS EXPLAIN.

- 11. Provide an updated loss history dated within 60 days for the past 5 years (including the current year) on a report-year basis. Loss data must include the incident/occurrence date, report date/claim made date, expense payments, indemnity payments, expense reserves, indemnity reserves, description of allegation and close date.

**AUTHORIZATION**

I have answered the questions in the Application to the best of my ability and declare that, to the best of my knowledge, the statements set forth herein are true and correct. My signing of the Application does not bind the Insurance Company to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a policy be issued.

**FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

**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.**