

In this document, Nighthawk refers to a contracted service providing radiology services to other radiology groups, usually during off hours.

Names of Physicians contracting for nighthawk services: _____

Name and address of facility contracting services: _____

1. Name of Nighthawk service: _____
2. Website: _____
3. Where is the principle corporate office located? _____
4. What are the addresses of any offices in Washington State?

5. What states are the images being transmitted from? _____
6. Please include a copy of all contracts pertaining to the Nighthawk Service. (These should include the read site and billing arrangements.)
7. Are there requirements for minimum levels of computers/internet lines at the read site? _____
What are they? _____
8. Who is responsible for computer failure or lack of transmission? _____
9. What hold harmless indemnity agreements are required of the Nighthawk service?

10. Does the Nighthawk service allow further subcontracting by their radiologists? _____

For the Reading Radiologist (s)

1. Where are the read sites? _____
2. Is the radiologist licensed to practice in these states? _____
3. Is the radiologist licensed to practice in the state where the imaging site is located? _____
4. Is the radiologist credentialed at the imaging site facility? _____
5. Please provide a copy of their professional liability coverage declarations.
6. Please provide a company loss/claims run.
7. Does their coverage include a provision for an extended reporting period endorsement? _____
8. Who actually communicates with the attending (ordering) physician at the local site concerning the interpretation of the image? _____

9. Are there protocols in place for reads needing immediate attention? _____
If so, please provide a copy.

For your Radiologist (employee)

1. Does your radiologist (employee) "overread" the interpretations submitted? _____
If so, what is the timing protocol for the "overread"? _____
2. Does your radiologist sign and submit the final report? _____
3. Is the original read permanently retained on file? _____
If so, by whom? _____

APPLICANT'S REPRESENTATION (READ CAREFULLY)

I hereby represent that the information contained in this questionnaire and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance in considering this application have been omitted. I agree that this shall be the basis of the coverage provided to me and that I will promptly notify Physicians Insurance of any changes contained herein.

SIGNATURE

DATE

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please return to:

Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
PO Box 91220
Seattle, WA 98111
(206) 343-7300 (800) 962-1399
F (206) 343-7100

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398
F (509) 456-0821

