

TELERADIOLOGY QUESTIONNAIRE

1. Practitioner name: _____

2. Name of facility where you practice: _____

Address: _____

3. Where are you receiving images from?

Inter-city: _____ Distance: _____

Intra-city: _____ Distance: _____

Out of state—list states and confirm licensing where you are practicing telemedicine:

State	Are you licensed to practice in this state? (Yes/No)

Out of country: _____

4. What types of images are being received? _____

5. What is the expected turnaround time? _____

6. Is there a local Radiologist to do the over read? _____

7. Please describe any contract arrangements related to teleradiology you may have and forward a copy of the contract for our review.

8. Please include the names of the physicians who are involved in contract arrangements and forward a copy of their professional liability coverage: _____

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 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

