FIRST INDEMNITY
INSURANCE GROUP
Your defense is our focus.

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SUPPLEMENTAL APPLICATION – MEDICAL BILLING

1. Name of applicant or insured: _____

2. Please indicate the percentage of the applicant's revenue that is derived from each of the following, must total 100%:

PRACTICE AREA	PERCENTAGE OF RE VENUE
a. Billing/coding	0.00% %
b. Audit	0.00% %
c. Transcription	0.00% %
d. Collections	0.00% %
e. Other (please describe)	0.00% %
Total	0.00% 100%

3. If collections services are provided, to what extent does the applicant pursue delinquent payments?

_____

4. Does the applicant provide collection services to related entities? ☐ Yes ☐ No

5. Does the applicant provide any records storage for a third party? ☐ Yes ☐ No

   If "**Yes**," please provide details on security measures that are utilized to maintain privacy:

_____

6. Does the applicant have HIPAA compliance procedures in place? ☐ Yes ☐ No

SIGNATURE IN FULL: _____ DATE: _____

PRINT NAME: _____

ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED

Agency Name and Address: _____

Person Submitting Application: _____

Telephone Number: _____ Email: _____