

# Procedure Change Request Form Physician

Effective Date of Change \_\_\_\_\_

Policy Number \_\_\_\_\_

Insured Name \_\_\_\_\_

**A. INDICATE THE AVERAGE WEEKLY NUMBERS, UNDER EACH OF THE FOLLOWING CATEGORIES, FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE** (If you practice in multiple states, please identify the following information for each state.)  
Please provide whole numbers (no ranges i.e. > <) If "none" please enter "0" (zero) in the space provided below.

PATIENTS SEEN PER WEEK \_\_\_\_\_ HOURS PER WEEK \_\_\_\_\_ WALK-IN PATIENTS PER WEEK \_\_\_\_\_

**NOTE: ALL PERCENTAGES REQUESTED BELOW FOR SPECIALITIES, PROCEDURES AND SURGICAL ACTIVITIES ARE OF YOUR TOTAL PRACTICE**  
**\*\*Please enter complete name of speciality/sub speciality.\*\***

**B. WHAT IS YOUR PRESENT SPECIALITY?** \_\_\_\_\_ % OF TOTAL PRACTICE \_\_\_\_\_  
What is your sub-speciality? \_\_\_\_\_ % OF TOTAL PRACTICE \_\_\_\_\_  
MUST EQUAL 100%

**C. PLEASE INDICATE ANY PROCEDURES WHICH YOU WILL BE DISCONTINUING AND WHEN** \_\_\_\_\_

**D. PLEASE CHECK ANY OF THE FOLLOWING PROCEDURES YOU ARE CURRENTLY PERFORMING IN YOUR PRACTICE:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abortions<br><input type="checkbox"/> Acupuncture<br><input type="checkbox"/> Therapeutic/Local Anesthetic<br><input type="checkbox"/> General Anesthetic<br><input type="checkbox"/> Angiography<br><input type="checkbox"/> Angioplasty<br><input type="checkbox"/> Arthroscopy<br><input type="checkbox"/> Arteriography<br><input type="checkbox"/> Assisting in major surgery<br><input type="checkbox"/> Own Patients Only<br><input type="checkbox"/> Own and Other than own patients<br><input type="checkbox"/> Blepharopigmentation<br><input type="checkbox"/> Blepharoplasty-Brow lifts<br>Cosmetic ___ % of Total Practice<br>Reconstruction ___ % of Total Practice<br><input type="checkbox"/> Botox ___ % of Total Practice<br><input type="checkbox"/> Breast Implants<br>Cosmetic ___ % of Total Practice<br>Reconstruction ___ % of Total Practice<br><input type="checkbox"/> Bronchoscopy<br><input type="checkbox"/> Bronco-esophagology<br><input type="checkbox"/> Cataract Surgery<br><input type="checkbox"/> Cryosurgery (other than external lesions)<br><input type="checkbox"/> Dermatological procedure done under general anesthesia<br><input type="checkbox"/> ERCP<br><input type="checkbox"/> D & C<br><input type="checkbox"/> Phenol Facial Peels<br><input type="checkbox"/> Diagnostic Embolization<br><input type="checkbox"/> Anesthesia - General/Spinal/Caudal<br><input type="checkbox"/> Pulse Oximetry<br><input type="checkbox"/> End Tidal CO2 Analyzer<br><b>Hair Transplants</b><br><input type="checkbox"/> Scalp Excision/Transplantations<br><input type="checkbox"/> Plug Technique/MiniGraph<br><input type="checkbox"/> Laproscopic Cholecystectomy<br><input type="checkbox"/> Laparoscopy<br><input type="checkbox"/> Laser Surgery<br><input type="checkbox"/> Liposuction<br><input type="checkbox"/> Lymphangiography<br><input type="checkbox"/> High Velocity / Low Amplitude (HVLA) on patients 18 years of age or older<br><input type="checkbox"/> High Velocity / Low Amplitude (HVLA) on patients younger than 18 years of age<br>_____ % Osteopathic Manipulation Therapy on patients 18 years of age or older<br>_____ % Osteopathic Manipulation Therapy on patients younger than 18 years of age | <input type="checkbox"/> Lithotripsy<br><input type="checkbox"/> Major Gynecological Surgery<br><input type="checkbox"/> Myelography<br><input type="checkbox"/> Mammograms<br><input type="checkbox"/> Needle Biopsy<br><b>Nerve Blocks</b><br><input type="checkbox"/> Lumbar Epidural Steroid<br><input type="checkbox"/> Paraspinal<br><input type="checkbox"/> Sciatic<br><input type="checkbox"/> Facet<br><input type="checkbox"/> Paravertebral<br><input type="checkbox"/> Peripheral<br><input type="checkbox"/> Myofascial<br><input type="checkbox"/> Occipital<br><input type="checkbox"/> Triggerpoint Injection<br><input type="checkbox"/> Intrathecal Pumps<br><input type="checkbox"/> Spinal Cord Stimulators<br><input type="checkbox"/> Phlebography<br><input type="checkbox"/> Pneumoencephalography<br><input type="checkbox"/> Radial/Laser Keratotomy<br><input type="checkbox"/> Radiation/X-Ray Therapy<br><input type="checkbox"/> Radiopaque Dye<br><input type="checkbox"/> Non-Ionic Only<br><input type="checkbox"/> Shock Therapy<br><b>Sigmoidoscopy</b><br><input type="checkbox"/> 60 cm or less<br><input type="checkbox"/> Greater than 60 cm<br><input type="checkbox"/> Colonoscopy<br><input type="checkbox"/> Polypectomy<br><input type="checkbox"/> Gastrointestinal Endoscopy<br><input type="checkbox"/> Biopsy (Endoscopic)<br><input type="checkbox"/> Peritoneoscopy<br><input type="checkbox"/> Laser Therapy (Endoscopic)<br><input type="checkbox"/> Laser Therapy (Non-Endoscopic)<br><b>Pacemakers</b><br><input type="checkbox"/> Permanent<br><input type="checkbox"/> Temporary | <input type="checkbox"/> Silicone Injections<br><input type="checkbox"/> Skin Flap/Grafts<br><input type="checkbox"/> Cosmetic ___ % of total practice<br><input type="checkbox"/> Reconstruction ___ % of total practice<br><input type="checkbox"/> With arterial blood supply other than cancer therapy<br><input type="checkbox"/> Oxidation Therapy<br><input type="checkbox"/> Prolotherapy<br><input type="checkbox"/> Chelation Therapy<br><input type="checkbox"/> Electromagnetic Therapy<br><input type="checkbox"/> Rectal Ozone Therapy<br><input type="checkbox"/> Swan-Ganz Catheterization<br><input type="checkbox"/> Right Heart Catheterization (Other Than CVP Lines)<br><input type="checkbox"/> Left Heart Catheterization<br><input type="checkbox"/> Tubal Ligations<br><b>Vasectomies</b><br><input type="checkbox"/> Own Patients Only<br><input type="checkbox"/> Own and Other than own patients<br><input type="checkbox"/> Weight Control Therapy/Surgery ___ % of total practice<br><input type="checkbox"/> Medication-Weight Control<br><input type="checkbox"/> Gastric Bubble<br><input type="checkbox"/> Gastric Stapling<br><input type="checkbox"/> Other (Type): _____<br><b>Prenatal Practice</b><br><input type="checkbox"/> See patients during the first & second trimester<br><input type="checkbox"/> See patients to term but do not perform delivery<br><input type="checkbox"/> See patients to term and perform delivery<br><input type="checkbox"/> Normal Obstetrical Deliveries<br>How many per year? _____<br><input type="checkbox"/> Cesarean Sections<br>How many per year? _____<br><input type="checkbox"/> Other Medical Techniques<br><b>List Procedures (do not restate your specialty)</b><br>_____<br>_____<br>_____ |
|--|---|---|

# Procedure Change Request Form - Physician (continued)

E. If you devote more than 25% of your practice to OMT, please answer both questions below:

1. Do you have an informed consent discussion with all your patients regarding your choice of OMT?  Yes  No
2. Please describe the use of x-ray or imaging technology used in your practice (i.e. this required prior to manipulation etc.)

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F. INDICATE THE PERCENTAGE OF YOUR TOTAL PRACTICE DEVOTED TO THE FOLLOWING SURGICAL ACTIVITIES

- |  |                    |                                      |
|--|--------------------|--------------------------------------|
| ___% Plastic (reconstruction only)       | ___% Cardiac       | ___% Orthopedic (Including Back)     |
| ___% Plastic (Cosmetic Enhancement Only) | ___% Vascular      | ___% Orthopedic (Not Including Back) |
| ___% Hand                                | ___% Neosurgery    | ___% Ophthalmology                   |
| ___% Traumatic                           | ___% Obstetrics    | ___% Urology                         |
| ___% Thoracic                            | ___% Gynecology    | ___% Other (Describe) _____          |
| ___% Otorhinolaryngology                 | ___% Endocrinology |                                      |
| ___% Neoplastic                          | ___% Nephrology    |                                      |

G. IN THE LAST TEN (10) YEARS,

1. Have you discontinued major surgical procedures, performance of Obstetrics, or any other medical activity?  Yes  No  
If Yes, list procedures/activities, date discontinued and reason for discontinuing. \_\_\_\_\_
2. Have you ever been a representative of a Predicle Screw Manufacturer?  Yes  No  
If Yes, please attach an explanation. \_\_\_\_\_
3. Have you performed weight-control surgery or prescribed weight control medication?  Yes  No
4. If Yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?  
 <1%  1%-10%  11%-50%  >50%
5. If Yes, what percentage of your practice (% of patient care) was devoted to performing weight control procedures?  
 <1%  1%-10%  11%-50%  >50%
6. Do you have ownership interests in a weight control clinic?  Yes  No
7. If Yes, what is the name of the weight control clinic with which you have affiliated? \_\_\_\_\_

H. IF YOU USE SILICONE GEL/SALINE BREAST IMPLANTS, DO YOU USE THE MANUFACTURER'S INFORMED CONSENT FORMS IN ADDITION TO YOUR NORMAL INFORMED CONSENT PROCEDURE?  Yes  No

I. DO YOU SERVE IN A HOSPITAL EMERGENCY ROOM FOR WHICH YOU REQUIRE MEDICAL PROTECTIVE COVERAGE?

- 1.) If Yes, number of hours per month: \_\_\_\_\_
- 2.) If Yes, are the hours you work in the ER the minimum number of hours required to maintain hospital privileges?  Yes  No  
*If you have emergency room activities which are covered by another professional liability insurance policy, complete question I.*

J. WILL YOU BE PERFORMING ACTIVITIES WHICH WILL BE COVERED BY ANOTHER PROFESSIONAL LIABILITY POLICY?  Yes  No

If Yes, complete the following:  Employee  Independent Contractor  Resident/Fellow  Faculty

Practice name and location(s) \_\_\_\_\_

Name of Carrier: \_\_\_\_\_

Policy Number \_\_\_\_\_

I hereby declare that the above statements and particulars are true and the I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_