

# PMIS

Managed Care Professional Liability Quick Quote

Please use this Quick Quote form to submit your current information to PMIS:

Please send me an application.

Please have a representative call me \_\_\_\_\_.

Contact Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Title: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_ Fax number: \_\_\_\_\_ Phone number: \_\_\_\_\_

Applicant's for insurance's name:

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact person:

Applicant is: \_\_\_\_\_ for profit: \_\_\_\_\_ not for profit: \_\_\_\_\_ joint venture: \_\_\_\_\_ other: \_\_\_\_\_

Is Applicant owned, managed or controlled by any other medical care of health care entity?

If yes; explain: \_\_\_\_\_  
\_\_\_\_\_

Model type: HMO: \_\_\_\_\_ group: \_\_\_\_\_ staff: \_\_\_\_\_ IPA: \_\_\_\_\_ MSO: \_\_\_\_\_  
PHO: \_\_\_\_\_ TPA: \_\_\_\_\_ UR contractor: \_\_\_\_\_ Other (explain): \_\_\_\_\_

Gross revenue: Last 12 months: \_\_\_\_\_ Next 12 months: \_\_\_\_\_

Professional services performed and revenues for each: yes/no revenues

Medical care claims handling and adjusting: \_\_\_\_\_

Prospective and /or concurrent UR: \_\_\_\_\_

Selection and credentialing of medical care providers: \_\_\_\_\_

Peer and /or management review of \_\_\_\_\_

contracted medical care providers: \_\_\_\_\_

Administrative or mgmt. services for the benefit of plan members:

Marketing of medical care services: \_\_\_\_\_

Any other (describe): \_\_\_\_\_

Enrollment: \_\_\_\_\_ Last 12 months \_\_\_\_\_ Next 12 months \_\_\_\_\_

Total number of enrollees: \_\_\_\_\_

Total number of patient visits: \_\_\_\_\_

What states? \_\_\_\_\_

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What % in muni/gov't programs: \_\_\_\_\_

Physicians under contract: \_\_\_\_\_

Surgeons under contract: \_\_\_\_\_

Hospitals under contract: \_\_\_\_\_

Current coverage limits: \_\_\_\_\_ Deductible: \_\_\_\_\_ Current carrier: \_\_\_\_\_

Effective date: \_\_\_\_\_ Current Premium: \_\_\_\_\_ Retroactive date: \_\_\_\_\_

Can you provide a copy of the existing policy, complete with endorsement and declarations pages (the face sheets showing the names, addresses, indemnity periods, retroactive dates, limits, etc.) so that we may properly match the new quotation to your retros and coverage terms? If so, can you fax or mail to us.

Can you provide an updated loss run or claims history; one generated by your carrier? If so, can you fax or mail to us?

For what reason(s) are you seeking new quotations?