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TELEMEDICINE QUESTIONNAIRE FOR PROFESSIONAL LIABILITY COVERAGE

Please return the questionnaire within 14 days

Policy Number: _____

First name: _____ Middle name: _____ Last name: _____

License Type: _____ Medical Specialty: _____ Male Female

Professional email address: _____ Office phone: _____

1. Briefly describe your telemedicine practice and the service you offer to your patients.

2. What percentage of your medical practice is dedicated to telemedicine? _____%

3. What percentage of your telemedicine care involves nursing homes, residential facilities, long term care, and/or behavioural health? _____%

4. What percentage of your telemedicine work involves care in emergency situations? _____%

5. Do you practice telemedicine while physically outside the state of Texas? Yes No

If yes, please provide the name of the state(s): _____

6. Do you practice telemedicine for patients who are physically outside the state of Texas? Yes No

If yes, please provide the name of the state(s): _____

7. Does your practice comply with all Texas requirements for Telemedicine (e.g. TMB Rule 174 and Texas Occupational Code 111), and corresponding jurisdictional requirement in **each state** where you practice? Yes No

8. Do you meet the medical licensing requirements in **each state** where you practice telemedicine and those in states where your patients reside? Yes No

9. Does your office have written policies & procedures in place for telemedicine care? Yes No
10. Do you have the necessary infrastructure and equipment to provide telemedicine care? Yes No
11. Is your telemedicine work restricted to care related to your formal medical training? Yes No
12. Are written protocols in place for telemedicine patients who need emergency care? Yes No
13. Does your practice follow up to confirm receipt of ordered labs and consults provided via telemedicine? Yes No
14. Are protocols in place at the host facility to ensure timely and adequate reporting of reviews? Yes No
15. Do you provide the official report directly to the ordering health care provider? Yes No
16. Are all telemedicine visits captured in your EHR? Yes No
17. Do you have a contract with a telemedicine organization to provide patient care? Yes No
 If yes, with whom? _____
 Do they provide coverage for your work? _____
18. Do you delegate authority to others outside your practice to treat patients via telemedicine? Yes No
 If yes, how many others outside of your practice are authorized? _____
19. Do you provide telemedicine care to incarcerated patients? Yes No
20. Do you monitor electronic Intensive Care Units (eICUs)? Yes No
 If yes, how many at one time? _____
 Do you obtain and adhere to the procedure/protocol information from the host facility? Yes No
23. Do you perform/assist with telesurgery or proctor surgical procedures performed on patients' location at a remote site? Yes No

I hereby warrant and represent that the foregoing information is true and correct. I understand and agree that this questionnaire and the statements therein become a part of the policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this questionnaire contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage.

Provider/Applicant Signature: _____

Printed Name: _____ Date Signed: _____