GenStar

# SUPPLEMENTAL APPLICATION

## PAIN MANAGEMENT
## MISCELLANEOUS HEALTHCARE FACILITIES

*This application must be completed, signed and dated by the applicant. All questions must be answered completely. The information is required to make an underwriting and pricing evaluation. Your answers are considered legally material to that evaluation. If any question does not apply, indicate NOT APPLICABLE. If space is not sufficient to properly answer the question, please provide the details in the Additional Information section of this form or you may attach a separate page using your letterhead. To use this form, you may mouse click on a field or move between fields using the tab key. To check a box, you may mouse click or press the space bar.*

## I. GENERAL INFORMATION

| | | |
|---|---|---|
| 1 | Applicant Name: | |
| | Entity Name | |
| | Primary Office Address: | Telephone No.: |
| | City: | County: |
| | State: | ZIP: |

## II. TRAINING and EDUCATION

1 What percentage of your practice is devoted to acute pain management, and what percentage is devoted to chronic pain management?

Acute Pain Management % Chronic Pain Management %

Have these percentages differed by more than 20% in either area, in any annual period, during the last 3 years?

☐ Yes ☐ No If Yes, please explain on letterhead.

2 Please indicate the clinic's area of concentration and the estimated percentage for each category.

| | |
|---|---|
| ☐ Lower Back/Spine % | ☐ Degeneration disc disease % |
| ☐ Arthritis % | ☐ Cancer Pain % |
| ☐ Crohn's Disease % | ☐ Fibromyalgia % |
| ☐ Headaches / migraines % | ☐ Jaw Pain / TMJ % |
| ☐ Sport Related Injuries % | |

☐ Other, please specify: %

3 Have these percentages differed by more than 20% in any area, in any annual period, during the last 3 years?

☐ Yes ☐ No If Yes, please explain on letterhead.

## III. *TYPES OF PROCEDURES*

| Procedures | Projected Next Year | Current Year | Last Year | Location of Procedure Clinic (C), Hospital (H), Surgery Center (S) |
|---|---|---|---|---|
| ☐ Drug Treatment – Opiods, corticosteroids, antidepressants, anticonvulsants | | | | |
| ☐ TENs | | | | |
| ☐ Counseling | | | | |
| ☐ Biofeedback | | | | |
| ☐ Massage | | | | |
| ☐ Physical Therapy | | | | |
| ☐ Acupuncture | | | | |
| ☐ PCA Pumps | | | | |
| ☐ Trigger Point Injections | | | | |
| ☐ Electro Thermal Therapy | | | | |
| ☐ Nerve Blocks | | | | |
| ☐ Facet Joint Blocks | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | ☐Chiropractic without anesthesia | | | | |
| | ☐Epidural Injections – Not Obstetric related | | | | |
| | ☐Chiropractic Manipulation/Adjustment under anesthesia | | | | |
| | ☐Spinal Cord Stimulation | | | | |
| | ☐Spinal Drug Delivery System | | | | |
| | ☐**Other**: please specify | | | | |
| | Is a crash cart available at each location procedures are preformed? ☐ Yes ☐No | | | | |

## VII. ACKNOWLEDGEMENTS, AUTHORIZATION and SIGNATURE

This applicant declares that the information contained in this supplemental application is true and that no material facts have been suppressed or misstated. The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations. This applicant understands that incorrect information could void coverage.

| | |
|---|---|
| Signature: | Date: |
| Printed Name: | Title/Position (Officer, Partner, etc): |