

Practitioner Name: _____

Policy Number: _____

Please answer all questions.

1. Do you perform refractive surgery? Yes No

If so, which types of refractive surgery do you perform and approximately how many surgeries per month do you perform of each?

- LASIK _____
- PRK _____
- RK _____

2. Please provide information regarding your training and certification for each type of surgery identified above that you perform:

3. Which laser do you use? _____

4. Are you certified by the laser manufacturers? Yes No

5. Does all of your usage of the laser equipment, including hardware and software, fall within FDA guidelines?
 Yes No

6. To date, approximately how many of each surgery have you performed? _____

7. What is your total average number of all patients seen per week? _____

How many refractive surgeries do you perform per week _____ or per month _____?

8. Do you provide all pre- and post-operative care and follow-up? Yes No
If no, please provide information regarding your evaluation pre- and post-operatively. _____

If optometrists provide any of this care, please describe your practice relationship with them (e.g., employees, independent contractors, independent practices). _____

9. How many pre-operative visits are scheduled with the patient prior to surgery? _____

How many days in advance are these scheduled? _____
Which of these visits and evaluations are conducted by you personally? _____

10. At what intervals do you schedule post-operative follow-up visits? _____

11. Please describe in detail your informed consent process. Please attach a copy of the informed consent form you use. _____

12. What percentage of potential candidates do you reject? _____

13. Please include a list of contraindications for surgery: _____

14. Please describe other circumstances under which a patient might be rejected as a candidate for surgery:

15. Please identify all facilities where you perform these surgeries.

Name _____

Address _____

Name _____

Address _____

16. At which hospitals do you hold privileges? _____

17. Please describe any marketing or promotion of refractive surgery that you do:

I HEREBY REPRESENT THAT THE INFORMATION CONTINUED IN THIS APPLICATION AND ANY SUPPLEMENTARY SUBMISSION IS COMPLETE AND TRUE AND THAT NO MATERIAL FACTS WHICH ARE REASONABLY LIKELY TO INFLUENCE THE JUDGMENT OF PHYSICIANS INSURANCE HAVE BEEN OMITTED. I AGREE THAT THIS SHALL BE THE BASIS OF THE POLICY OF INSURANCE REQUESTED AND THAT I WILL NOTIFY PHYSICIANS INSURANCE OF ANY CHANGES CONTAINED HEREIN.

Date _____

Physician Signature _____

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please return to: Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
1730 Minor Avenue, Suite 1800
Seattle, WA 98101
(206) 343-7300 (800) 962-1399

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398

