



Specialty Supplemental Application – Urgent Care

IMPORTANT NOTICE

This is a SUPPLMENT to an MIEC application. This document alone is insufficient to apply for and be approved for coverage with MIEC. Be sure to submit this along with your complete signed and dated MIEC application.

APPLICANT

Entity or Last name, first name

URGENT CARE MEDICINE

A. Please list all locations where you provide services, and the corresponding estimated and actual visit information. Please attach visit information for at least the last five (5) years; however, 10 years is preferred.

Table with 5 columns: Name of location, Date opened, Lease/Own space, Estimated visits for next 12 months, Actual visits for the last 12 months

B. What percentage of your overall visits are provided by physicians _____ or Advanced providers (NP/PA) _____ ?

C. Are you considered the primary care provider for your patients? [] Yes [] No

If yes, what percentage of overall visits does this comprise? _____ %

D. Do you specialize in pediatric care? [] Yes [] No

E. Is resuscitative equipment kept on site? [] Yes [] No

F. Do you provide any of the following services at any location?

Pharmacy [] Yes [] No

X- ray [] Yes [] No

Laboratory [] Yes [] No

Independent medical evaluations (IME) [] Yes [] No

Work/sport physicals [] Yes [] No

COVID vaccines/testing [] Yes [] No

G. Do you provide anesthesia services? [] Yes [] No

If yes, what kind? _____

Conscious _____ %

Local _____ %

General _____ %

Other _____ %

If Yes, who is providing the anesthesia services? _____

H. Are you providing any services, volunteer or not, outside of the traditional urgent care setting (e.g. first aid coverage at sporting events)? [] Yes [] No

If yes, please provide a description. _____

Are you requesting these services be covered on this policy? [] Yes [] No

SIGNATURE

Signature

Date