



ARGO PRO

Medical Solutions

## ALLIED MEDICAL - CLINICS SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

Please see the Argo Pro Allied Medical General Application to complete a schedule of physicians associated with this facility. No liability coverage for physicians will be included with this quote unless a physician application is submitted and coverage is specifically included on the quote.

### I. APPLICANT INFORMATION

1. Applicant Name: \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_
3. City, State, Zip: \_\_\_\_\_
4. County: \_\_\_\_\_ 5. Telephone Number: \_\_\_\_\_
6. Indicate type of clinic:
 

<input type="checkbox"/> Abortion Center	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Alternative Medicine	<input type="checkbox"/> Occupational Health
<input type="checkbox"/> Family Practice/General Practice	<input type="checkbox"/> Sleep Studies
<input type="checkbox"/> Free Clinic	<input type="checkbox"/> Urgent Care
<input type="checkbox"/> Immunization	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Other (please describe): _____	

### II. OPERATIONS

1. a. Does the Applicant perform any surgery besides incision of boils and superficial abscesses or suturing skin and superficial fascia?  Yes  No  
 b. If Yes, list all invasive procedures: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
2. a. Does the Applicant perform any anti-aging procedures, including Botox or other injectibles?  Yes  No  
 b. If Yes, completion of a Medical Spa/Anti-Aging Clinics Supplemental Application is required.
3. Does the Applicant perform abortions and/or menstrual extractions?  Yes  No
4. a. Does the Applicant administer anesthesia other than topical or local infiltration?  Yes  No  
 b. If Yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
5. a. Does the Applicant prescribe or provide drugs for weight reduction for patients?  Yes  No  
 b. If Yes, please indicate percentage of practice devoted to weight reduction: \_\_\_\_\_ %  
 c. If Yes, please list medications prescribed or used: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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6. a. Does the Applicant administer any methadone treatment?  Yes  No  
 b. If Yes, indicate the number of treatments administered during the:  
     Last 12 Months: \_\_\_\_\_ Next 12 Months: \_\_\_\_\_  
 c. If Yes, please attach a description of treatment and controls used.
7. a. Does the Applicant provide imaging services?  Yes  No  
 b. If Yes, provide a description of services, and indicate whether images are interpreted by the Applicant:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8. Indicate \_\_\_\_\_ % Bariatrics \_\_\_\_\_ % Pain Management  
 percentage of \_\_\_\_\_ % Communicable Disease \_\_\_\_\_ % Pediatric  
 patients/clients: \_\_\_\_\_ % Dental \_\_\_\_\_ % Physical Rehabilitation  
 \_\_\_\_\_ % Disability Evaluation \_\_\_\_\_ % Psychiatric  
 \_\_\_\_\_ % Family Planning \_\_\_\_\_ % Research/Experimental  
 \_\_\_\_\_ % Free Clinic \_\_\_\_\_ % Sleep Disorders  
 \_\_\_\_\_ % Hemodialysis \_\_\_\_\_ % Stress Testing  
 \_\_\_\_\_ % Holistic Medicine \_\_\_\_\_ % Substance Abuse  
 \_\_\_\_\_ % Obstetrical \_\_\_\_\_ % Surgical  
 \_\_\_\_\_ % Oncology \_\_\_\_\_ % Urgent Care  
 \_\_\_\_\_ % Other – Please describe: \_\_\_\_\_

\* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

\* Not applicable in all states

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_

Authorized Signature on behalf of Applicant Sub-Producer

\_\_\_\_\_

Title/Date Producer

**SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.**