MIEC
6250 Claremont Avenue
Oakland, CA 94618-1324

800.227.4527 **toll free**
510.654.4634 **fax**

miec.com

Specialty Supplemental Application — Obstetrics/Gynecology

IMPORTANT NOTICE
This is a SUPPPLMENT 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

OBSTETRICS — ANSWERS A-H

A. What type of deliveries do you perform?
- ☐ Vaginal
- ☐ C-section
- ☐ VBAC

B. Where do you perform deliveries? And provide a % of your total deliveries
- ☐ Hospital _____%
- ☐ Birthing Center (stand-alone) _____%
- ☐ Home_____%
- ☐ Other_____%

C. Do you work with any of the following professionals during delivery
- ☐ Acupuncturist
- ☐ Certified Nurse Midwife (CNM)
- ☐ Doula
- ☐ Nurse Practitioner (NP)
- ☐ Physician Assistant (PA)
- ☐ Surgical Assistant
- ☐ Other: _____

D. For **your** patients who deliver after hours, do you (check all that apply):
- ☐ Take your own call
- ☐ Use Laborists

E. Do you provide Laborist services? ☐Yes ☐No If Yes, do you want those services covered by this policy? ☐Yes ☐No

F. How many high-risk pregnancies do you manage yearly?_____

G. Do you allow patients to develop their own alternative birth plans? ☐Yes ☐No

If yes, what kinds of requests are made? (check all that apply):
- ☐ Home births
- ☐ Water births
- ☐ Limited or no antenatal screening
- ☐ No continuous, invasive fetal monitoring
- ☐ Other: _____

H. Have any of the following adverse patient outcomes, related to deliveries, occurred in your practice within the last two (2) years?
- ☐ Unexpected deaths (including stillbirths)
- ☐ Significant neurological injury or functional deficit

If yes, did you report them to your professional liability carrier? ☐Yes ☐No

GYNECOLOGY — ANSWERS I-M

I. Do you specialize in any of the following:
- ☐ Maternal Fetal Medicine
- ☐ Uro-gynecology
- ☐ Reproductive Endocrinology and infertility
- ☐ Gynecologic Oncology

GYNECOLOGY (continued) — ANSWERS J-M

J. What is the percentage of patients in your practice under the age of 18?_____ %

K. Do you care for patients after the first trimester (12 weeks) of pregnancy? ☐Yes ☐No

If yes, and you do **NOT** perform deliveries, at what point do you refer these patients to a different care provider?_____

L. Do you offer or perform the following services?

Mona Lisa touch services ☐Yes ☐No

Genetic testing ☐Yes ☐No **If yes,** are the results discussed with a medical geneticist or genetic counselor? ☐Yes ☐No

Elective Cosmetic procedures ☐Yes ☐No **If yes, please complete the Plastic/Cosmetic Surgery Procedure supplement**

Robotic surgeries ☐Yes ☐No

IVF ☐Yes ☐No **If yes,** do you operate a fertility lab on-site? ☐Yes ☐No **If yes, please complete additional supplement**

Pain management (more than medication only) ☐Yes ☐No

Assisting in major surgery/delivery ☐Yes ☐No

M. Check all procedures/categories that you perform or apply to your practice:

Diagnostic/No Surgery
- ☐ Prenatal Care
- ☐ Biopsy
- ☐ Weight Loss Management/Treatment
- ☐ LEEP
- ☐ Colposcopy

Minor Surgery
- ☐ Aspiration of cyst of breast
- ☐ Hormone replacement therapy
- ☐ Cyrosurgery
- ☐ Fertility (non-IVF)
- ☐ Dilation and Curretage (D&C)
- ☐ IUD/Subdermal contraceptive

Major Surgery
- ☐ Gender Affirming Surgery
- ☐ Hysterectomy
- ☐ Myomectomy
- ☐ Oophorectomy
- ☐ Polypectomy
- ☐ Trachelectomy
- ☐ Tubal Ligation

TELEMEDICINE — ANSWERS N-U

N. Do you provide services via telemedicine? ☐Yes ☐No

If yes, please answer questions O-U.

O. What type of patients do you see via telemedicine? Check all that apply:
- ☐ New patients
- ☐ Established patients
- ☐ Referrals/consultations
- ☐ Other:_____

P. Do you see patients in the following environments?
- ☐ Prisons/jails
- ☐ Rural Areas
- ☐ Hospital/Emergency Department/ICU
- ☐ Nursing home/Assisted Living
- ☐ Schools
- ☐ Private homes (not considered rural)

Q. What is the average duration of each telemedicine session?_____

R. Do you require an in-person visit/session after a set number of telemedicine visits? ☐Yes ☐No

If yes, how many visits/sessions?_____

S. Who manages the follow up, if needed, related to a telemedicine session?_____

T. Do patients have the option to opt out of telemedicine? ☐Yes ☐No

If yes, and the patient opts out, what are the next steps?_____

U. Are there conditions you will **not** consult/diagnose via telemedicine? **If yes,** please describe: _____

SIGNATURE

SIGNATURE

_____ _____

Signature Date