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Supplemental Application — Medical Laboratory

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

MEDICAL LABORATORY — ANSWERS A-G

A. Please list all locations where you provide services, and the corresponding estimated and actual revenue generated from tests performed.

Name of Location (include the address)	Years in operation	Lease/ own space	Estimated revenue/receipts for next 12 months	Actual revenue/receipts for last 12 months

B. Please estimate the percentage of revenue from each source

Charitable contributions $____________
Government Funding $ ____________
Fee for Services $____________
Other (please specify)______________________________ $ ____________

C. Please indicate the amount of each type of test performed across **ALL** locations

Type of Test	# of annual tests	Percent of total
Cytopathology		
Histopathology		
STI testing		

Type of Test	# of annual tests	Percent of total
Drug or alcohol testing		
DNA testing to include paternity		
Other not described or listed above		

D. Please provide percentage of specimens

Collected directly from patients ____________%
Received from outside sources ____________%

E. Please provide the percentage of services provided for:

Hospitals____________%
Nursing Homes ____________%
Physician Offices ____________%
Veterinary Clinics____________%
Industrial Facilities ____________%
Others ____________%

F. Do you provide any mobile operations? ☐Yes ☐No **If yes,** what percent of services ____________%

G. Please indicate the number of the following types of professionals **EMPLOYED** by the imaging center

_____ Physicians
_____ Nurse Practitioner
_____ Physician Assistants
_____ Nurse (RN, LPN)
_____ Technician (EKG, X-ray, Lab)
_____ Phlebotomist
_____ Medical Assistant
_____ Other (please describe):____

H. Do you have a medical director? ☐ Yes ☐ No **If yes,** provide Name, Specialty, and license number.

Name ____________ Specialty ____________ License Number ____________

I. Is the facility licensed? ☐ Yes ☐ No

J. Has the facility/operational license ever been revoked, suspended or voluntarily surrendered? ☐ Yes ☐ No

If yes, please explain: ____________

K. Is the facility accredited/certified? ☐ Yes ☐ No **If yes,** by whom (check all that apply)

☐ CMS ☐ JCAHO ☐ AAAHC ☐ IAC ☐ ACR ☐ CLIA ☐ NIDA ☐ Other: ____________

L. Do you read or interpret any x-rays, medical images, pathology slides or other similar tests? ☐ Yes ☐ No

If yes, who is performing these services? ____________

If yes, are the results conveyed directly to the patient? ☐ Yes ☐ No

M. Are you involved in any of the following: (check all that apply)

☐ Blood banking or cross matching

☐ Manufacturing, dispensing or testing pharmaceuticals

☐ The use of radioactive material other than used in X-ray equipment

☐ Therapy or treatment procedures

☐ Medical, genetic, AIDS or drug research

☐ Manufacturer and/or sell laboratory equipment or supplies, reagants or software

N. Do you maintain any of the following resuscitative equipment? (check all that apply) ☐ Crash cart ☐ Defibrillator ☐ EKG ☐ Oxygen

Is all resuscitative equipment regularly maintained and kept up to date? ☐ Yes ☐ No ☐ N/A

O. Do you have emergency and transfer protocols in writing? ☐ Yes ☐ No

P. Are staff ACLS or BCLS certified? ☐ Yes ☐ No

Q. Do you have written policies and procedures that address (check all that apply)

☐ Contamination prevention and control

☐ Infection prevention and control?

If yes, which of the following guidelines are those policies based on (check all that apply)

☐ CDC ☐ State Department of Health ☐ Local Ordinances/Mandates ☐ Medical Specialty Society ☐ Other: ____________

SIGNATURE

SIGNATURE

____________ Signature

____________ Date