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**COVER-PRO<sup>SM</sup> APPLICATION**  
MEDICAL TRANSCRIPTIONIST SERVICE SUPPLEMENT

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1. Full name of the Applicant Firm:
2. Advise the Applicant's post secondary training relating to the medical transcription field:
3. Is the Applicant a:  
     Registered Medical Transcriptionist (RMT)  
     Certified Medical Transcriptionist (CMT)  
 Provide a list of all other relevant certifications, designations, and accreditations:
4. How many years has the Applicant been transcribing medical records: \_\_\_\_\_ years
5. Describe the controls and procedures the Applicant uses when transcribing to ensure proper editing, grammar, and accurate identification and usage of medical terminology:
6. Does the Applicant provide record storage or document management services for a third party? **If yes, please provide the security controls in place.** Yes    No
7. Does the Applicant have HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance procedures in place? **If yes, describe all procedures.** Yes    No
8. If working in a doctor's office, hospital or other medical setting, does the Applicant perform services other than medical transcription (i.e. scheduling appointments, answering phones)? **If yes, describe all services.** N/A    Yes    No
9. Does the Applicant perform transcription services for a medical specialty or field (i.e. radiology, pathology)? **If yes, list all specialties and years of field experience for each.** Yes    No

**I understand that the information submitted herein becomes a part of my Philadelphia Insurance Companies Cover-Pro<sup>sm</sup> application and is subject to the same conditions as stated on that application.**

Name (Please Print/Type)

Title (MUST BE SIGNED BY A PRINCIPAL PARTNER OR OFFICER)

\_\_\_\_\_  
Signature

Date

**ADDITIONAL INFORMATION**

**This section may be used to provide additional information to any question on this application. Please identify the question number to which you are referring.**

\_\_\_\_\_  
Signature

Date