



One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

COVER-PROSM APPLICATION
MEDICAL TRANSCRIPTIONIST SERVICE SUPPLEMENT

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
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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
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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
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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
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I understand that the information submitted herein becomes a part of my Philadelphia Insurance Companies Cover-Prosm 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