CONVENTUS
MEDICAL PROFESSIONAL LIABILITY INSURANCE

Pain Management Supplemental Application

Section I – General Information.

First Name	Middle Name/Initial	Last Name	Credentials (MD/DO)

Practice Name

Section II – Training

	Yes	No
Do you have a current Pain Medicine Certification from the American Board of Anesthesiology or American Board of Interventional Pain Physicians?		
Are you currently certified by the American Board of Pain Management?		
If you are NOT a pain management specialist, do you refer patients to a pain management specialist when treatment objectives are not met pursuant to *NJAC 13:35.76*??		
Have you started or discontinued any pain management procedures within the last 24 months		
If yes, please describe:		
Please indicate any additional training in pain management you have taken within the last 24 months.		
How long have you been performing pain management procedures?		

	Yes	No	
Are you registered with and do you use the NJ Prescription Monitoring Program (NJPMP) pursuant to *NJAC 13:45A-35.9*?			If no, please explain:
Do you delegate your authority to access the NJPMP to others pursuant to *NJAC 13:45A-35.8 and NJSA 45:1-44*?			If yes, please specify delegate (s) credentials:
Do you follow the NJ Board of Medical Examiners (BME) regulations for prescribing controlled substances pursuant to *NJAC 13:35.76*?			If no, please explain:
Do you participate in and refer patients to NJ's Medicinal Cannabis Program pursuant to NJAC *13:35-7A.1-13:35-7A.6*?			
If **yes**, do you follow NJ BME's regulation on holding a bona fide relationship with the patient you are registering pursuant to NJAC *13:35-7A.1-13:35-7A.6*?			If no, please explain:
Will you have completed your *MATE Act 8-hour training* per the DEA requirement by your next scheduled DEA registration?			If no, please explain:

Section III – Practice Profile

Do you provide/perform:	**Yes**	**No**	**If yes, what % of Practice**	**If yes, approximately how many patients per year**
Medication Management				
Interventional Pain Management				
Other, please specify:				

Section IV – Prescribing Practices

Do you Prescribe any CDS/Schedule II to V medications Yes No, initial here __________

If yes, please answer the following:

Yes	No	
		Do you prescribe Schedule II to V medications?
		Do you utilize a Patient Agreement for prescribing controlled drug substances (CDS) pursuant to *NJAC 13:35.76*?
		If no, please describe why not:
		Do you co-prescribe naloxone to chronic patients obtaining 90 Morphine Milligram Equivalents (MME) or more of opioids or the concurrent prescription of an opioid and a benzodiazepine pursuant to *NJAC 13:35.76*?

Yes	No	Do you prescribe:	# Currently Treating	# Anticipate Treating
		Buprenorphine		
		Methadone		
		Naltrexone		
		Medications for Drug Detoxification (Please specify)		

Section V– Types of Interventional Procedures

Do you perform any of the procedures listed in this section Yes No, initial here __________

If yes, please indicate all the procedures you perform.

✓	Procedures	# Annual Procedures	Location of Procedures Office (O), Hospital (H), Surgery Center (S)
	Discogram (Discography)		
	Endoscopic Rhizotomy		
	Endoscopic Foraminoplasty		
	Endoscopic Laminotomy		
	Epidural Injections		
	Facet Joint Injections		
	Intercostal Nerve Blocks (INBs)		
	Intra-articular Joint Injections		
	Intradiscal Electrothermal (IDET)/Annuloplasty		
	Ketamine Therapy		
	Medial Branch Blocks		
	Minuteman		
	Percutaneous Vertebral Discectomy		
	Occipital Nerve Block		
	Radiofrequency Ablation		

Do you perform any of the procedures listed in this section Yes No, initial here _________

If yes, please indicate all the procedures you perform.

✓	Procedures	# Annual Procedures	Location of Procedures Office (O), Hospital (H), Surgery Center (S)
	Regenerative Medicine (e.g., PRP Injections, Stem Cell)		
	Sacroiliac Joint Injections		
	Sympathetic Nerve Blocks		
	Trigger Point Injections		
	Vertiflex		
	Vertebroplasty/Kyphoplasty		
	Other, please specify:		

Do you perform any of the procedures listed in this section Yes No, initial here _________

If yes, please answer the following:

Yes	No	Procedures	# Annual Trials	# Annual Implants
		Peripheral Nerve Stimulation		
		Spinal Cord Stimulation		
		Intrathecal Pain Pump		
How many patients do you currently treat that have Intrathecal pain pumps?				
How many patients annually?				
Please specify typical frequency of medication refills of intrathecal pump				

Is a crash cart available at each location procedures are performed? Yes No

Do you follow a protocol for checking the cart on a regular basis and are the checks documented? Yes No

Section VI- Signature

Signature of Applicant: ____ Date: __________________________

Conventus reserves the right to reject any application that does not meet its underwriting standards.

NOTICE TO NEW JERSEY APPLICANTS

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, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALITIES.