Indication Request

Please complete and fax to 410-494-0926

Person requesting the Indication:

Name: _____

Email address: _____ Phone #: (____) _____ - _____

Best time to reach you (circle one): AM / PM

Date Submitted (mm/dd/yy): _____ / _____ / _____

# of Pages Submitted for Review: _____

- ❑ Type of Request (circle one): Individual Group
- ❑ If Group, name: _____
- ❑ Applicant's First Name _____
- ❑ Applicant's Last Name _____
- ❑ Practice Name _____
- ❑ State of practice _____
- ❑ County of practice _____
- ❑ Spine or Non-Spine? _____
- ❑ Surgical or Non-Surgical? _____
- ❑ Requested Effective Date _____
- ❑ Policy Type (circle one): Claims-Made Occurrence
- ❑ Who is your current carrier? _____
- ❑ What is your current premium payment? _____
- ❑ Retro Date (If Claims-Made) _____
- ❑ Limits Requested _____ / _____
- ❑ Hours worked per week _____
- ❑ Graduation Date (Month/Year): _____ / _____
- ❑ Residency/Fellowship End Date (Month/Year): _____ / _____
- ❑ Are you ABOS certified? (circle one): Yes / No
- ❑ Do you have any claims (circle one) : Yes / No If **yes**, how many _____
- ❑ **If yes,** please complete the attached claim evaluation form.
- ❑ Please attach any claim information that will help us evaluate any claims reported above.
- ❑ Please attach a copy of the current carrier's declaration page – IF AVAILABLE

*Any additional information which differs from attached application or which may be relevant to our review of this information (i.e., prior licensure actions or restrictions, prior insurance non-renewed, etc.)

Ortho Preferred

Claim Information

Please complete this form for each of your claims.

Applicant's Name _____

1. Patient's Name _____
   Date of Service _____
   Date Claim Notice Received _____
   Date the claim closed _____
   Was payment made on your behalf YES / NO
   If yes, please indicate the amount paid on your behalf $ _____

2. Patient's Name _____
   Date of Service _____
   Date Claim Notice Received _____
   Date the claim closed _____
   Was payment made on your behalf YES / NO
   If yes, please indicate the amount paid on your behalf $ _____

3. Patient's Name _____
   Date of Service _____
   Date Claim Notice Received _____
   Date the claim closed _____
   Was payment made on your behalf YES / NO
   If yes, please indicate the amount paid on your behalf $ _____

4. Patient's Name _____
   Date of Service _____
   Date Claim Notice Received _____
   Date the claim closed _____
   Was payment made on your behalf YES / NO
   If yes, please indicate the amount paid on your behalf $ _____