

**Express Quote Form - Anesthesiology**

**Practice Information**

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Hospital and/or Surgery Center Affiliations and % of your practice at each:

\_\_\_\_\_

Do you provide Pain Management Services (explain): \_\_\_\_\_

How many CRNA's do you employ? \_\_\_\_\_ Independent Contractors \_\_\_\_\_

Do you train/supervise residents or CRNA's (if yes, please describe)? \_\_\_\_\_

\_\_\_\_\_

Please describe any unusual or experimental procedures or services you offer:

\_\_\_\_\_

Have any claims been brought against you or your group in the past ten years? \_\_\_\_\_

If yes, please complete a claims supplement form for each claim (or provide copy of your claims history)

Contact Person / Phone Number and Email address: \_\_\_\_\_

Please provide information on any practice activities, changes in your practice, processes/procedures you have implemented, etc. that may help us understand your risk, or steps you have taken to mitigate risk:

\_\_\_\_\_

\_\_\_\_\_

**Fax this form to 866-422-2300 with the following information:**

- Copy of most recent professional liability application, or hospital credentialing application
- Curriculum Vitae for each physician applying for coverage
- Claims History, if applicable

**Or forward applications you already completed for another insurance company.**

The above information is accurate to the best of my knowledge. I understand that this information is confidential and being submitted to Doctors Direct Insurance solely for the purpose of receiving a preliminary premium indication.

\_\_\_\_\_  
Authorized Representative Signature / Date

\_\_\_\_\_  
Print Name