



Supplemental Questionnaire for Radiological Procedures

MAG Mutual Insurance Company

Policy Number:

Physician Name:

Check all diagnostic/medical/surgical procedures you perform and enter the appropriate number you perform each month where indicated:

- ( ) Angiography
( ) Venous
( ) Arterial
( ) Peripheral angioplasty
( ) Angioplasty \_\_\_ per mo.
( ) Cardiac catheterization
( ) Permanent pacemaker
( ) Left heart catheterization
( ) Coronary angioplasty (PTCA)
( ) Diskography
( ) ERCP
( ) Image guided Biopsy \_\_\_ per mo.
( ) Large Core Needle Biopsy \_\_\_ per mo.
( ) Lymphangiography
( ) Mammography \_\_\_ per mo.
( ) Myelography or phlebography
( ) Pneumoencephalography
( ) Radiation therapy
( ) Radiopaque dye injection (other than IVP) in the blood vessels, lymphatic, sinus tracts and fistulae
( ) Thrombolytic Therapy
( ) Tumor Ablation
( ) Uterine Fibroid
( ) Vertebroplasty \_\_\_ per mo.

( ) Diagnostic Procedures - Not including Mammograms

\_\_\_\_\_ of practice

( ) Interventional Procedures - ie. Angioplasty, Large Core Needle Biopsy, Catheterizations

\_\_\_\_\_ of practice

I hereby declare that the information provided by me in this supplemental application is true and complete to the best of my knowledge, recollection, and belief, and that I have not intentionally omitted, misrepresented or misstated any material fact(s).

Signature of Physician (Required)

Date



## Radiological/Imaging Facilities

Add'l information for HCS applicants

Dear Prospect,

To develop the premium for this entity, we will need a break down of the gross receipts by imaging type. We use different rates for each type of imaging. We will need a breakdown by **gross receipts** for the following:

- Angiography
- Veteboplasty
- PET Scan
- X-Ray
- Ultrasound
- CT
- MRI/MRA
- Mammography
- Bone Density
- Sterotactic Breast Biopsy