

Tail Coverage Letter MHMD Central Credentialing

Dear Applicant:

The Medical Staff Bylaws and/or Credentialing Manual of your Memorial Hermann facility requires Practitioners maintain professional liability insurance in such form and amounts as required by the Board of Directors. The Memorial Hermann Health System corporate bylaws were revised in October of 1997 to address a coverage gap, which occurred at one of the system Hospitals when a Practitioner's professional liability coverage lapsed when he did not purchase "tail" coverage when he changed claims-made carriers. The gap in professional liability coverage for this Practitioner created greater liability exposure for the other Practitioners with whom he practiced, as well as for the Hospital.

The corporate bylaws now specify that Practitioners must maintain continuous professional liability coverage for the professional services which he/she renders during his/her period of Medical Staff appointment, regardless of the date when coverage is canceled, terminated or non-renewed, or if the Practitioner obtains coverage from a new claims-made or occurrence carrier. "Tail" coverage with an unlimited reporting period must be purchased. This liability exposure could also be covered by purchasing "prior acts" coverage from a new claims-made carrier. "Tail" (or "prior acts") coverage must be obtained so that there will be no gap in coverage.

Beginning on July 1, 1998, whenever a Practitioner who carries claims-made coverage changes insurance carriers, he/she must provide documentation that they have obtained "tail" (or "prior acts") coverage with an unlimited reporting period. Attached is the form, which must be submitted within fifteen (15) days of changing claims-made carriers. If you have any questions regarding this requirement, please contact me at (713) 338-6453.

Sincerely,

Susie Weber
Director
MHMD Central Credentialing

Enclosure

Professional Liability Insurance Verification/Request Form

Name (Print): _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Telephone: _____ Fax: _____

Current Insurance

Carrier: _____

Period: (from) _____ (to) _____ Inception Date: _____

Limits of Liability: _____ Retroactive Date: _____

New Insurance (If Applicable)

Carrier: _____

Period: (from) _____ (to) _____ Inception Date: _____

Limits of Liability: _____ Retroactive Date: _____

Please attach a copy of your most recent Declarations Page and, if applicable, a copy of the Extended Reporting Endorsement ("Tail") as verification of coverage.

Printed Name: _____

Signature: _____ Date: _____