South Carolina Medical Malpractice Association
550 South Main Street, Suite 525, Greenville, SC 29601 – corporate office
864.240.5449 main 866.893.6270 toll-free 864-240-2750 fax
www.scmma.net

SC MMA
LOCUM TENENS COVERAGE REQUEST FORM

Instructions:

1. Please complete this form leaving no blanks.
2. The Locum Tenens Coverage Request form must be signed and dated by the SCMMA insured.
3. **Please submit the completed form to the SCMMA via email at Teresa.Anderson@marsh.com**
4. Once request is approved, a Locum Tenens Endorsement will be sent to you as evidence of coverage.
5. Please contact the SCMMA if you have any questions.

A. EMAIL COVER INFORMATION:

TO:

MMA Locum Tenens Request
Teresa.Anderson@marsh.com

____

FROM:

____ _____ / _____ / _____
Authorized Practice Representative Name *Date*

PRACTICE NAME: ____

NAME OF MMA INSURED REQUESTING LOCUM TENENS COVERAGE: _____________________________________

Phone: ____

Fax: ____ Total # of Pages: ___________

The information contained in this transmission is privileged and confidential. It is intended only for the use of the SCMMA. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this transmission is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone and return the original message to the South Carolina MMA via the U.S. Postal Service. Thank you.

B. General Locum Tenens Coverage Information:

Locum Tenens coverage is insurance for a healthcare provider who substitutes for a MMA insured during periods of temporary absence. This coverage can be provided only when the MMA insured is not practicing. MMA policies may be eligible for up to 45 days of Locum Tenens coverage per annual policy period. If you need an extension beyond the 45 day limit, you may request such an extension by submitting your request in writing to our office. The substituting provider must submit a completed SCMMA Locum Tenens Healthcare Provider Application to the MMA for approval. Once approved, Locum Tenens providers will remain eligible for coverage for one year.

A separate SCMMA Locum Tenens Coverage Request Form is required for each substitute period, and must be signed by the MMA insured. Requests for this coverage must be made prior to the beginning of each substitution period. Locum Tenens coverage cannot be provided on a retroactive basis if the request is made late.

If you have any questions about Locum Tenens coverage, or require special assistance, please contact the MMA Underwriting Department.

Important: The coverage afforded by this endorsement is excess insurance should the substitute provider have other insurance applicable to the loss under this policy. On an excess, contingent, or primary basis, this policy will come into effect only after such other insurance has been exhausted. This endorsement excludes all professional services rendered outside the state of South Carolina.

C. Locum Tenens Coverage Request Details:

1. MMA Insured Name (please print): ______________________________
2. MMA Insured Policy Number: ______________________________
3. MMA Insured Policy Period: Effective Date: _____ / _____ / _____ Expiration Date: _____ / _____ / _____
4. I request Locum Tenens coverage for the following substitute healthcare provider:

Name: ______________________________

Mailing Address: ______________________________

City: ____________________ State: ____________ Zip: __________

5. Insured's normal Shift/per Day is: __________ Hours per Shift __________ Shifts per Week
6. Requested Locum Tenens Coverage Period (Please request non-continuous coverage on a separate line):

				MMA Use Only:
__________ Coverage Date(s)	Shift:	__________ Start Time	to __________ End Time	__________ Total LT Days
__________ Coverage Date(s)	Shift:	__________ Start Time	to __________ End Time	__________ Total LT Days
__________ Coverage Date(s)	Shift:	__________ Start Time	to __________ End Time	__________ Total LT Days
__________ Coverage Date(s)	Shift:	__________ Start Time	to __________ End Time	__________ Total LT Days

7. Return Locum Tenens Endorsement to my office to the attention of: ______________________________
8. Return Locum Tenens Endorsement to my office via: ☐ Fax ☐ Email

8a. Please provide fax number or e-mail address: ______________________________

D. AUTHORIZATION:

______________________________ _____ / _____ / _____

Signature of MMA Insured Date

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