



Change of Financial Responsibility Form Out-of-State Telehealth Provider

Completed forms must be sent to:

Telehealth

4052 Bald Cypress Way, Bin C-11

Tallahassee, FL 32399-1708

Email: MQA.Telehealth@flhealth.gov

Name: _____
Last/Surname First Middle

Out-of-State Telehealth Registration Number: _____

Section 456.47(4)(e), F.S., requires **all** out-of-state telehealth providers to maintain professional liability coverage or financial responsibility that includes coverage for telehealth services provided to patients in Florida. The coverage amount must be equal to or greater than the requirements in sections 456.048, 458.320 (for the practice of medicine), or 459.0085 (for the practice of osteopathic medicine), F.S.

FINANCIAL RESPONSIBILITY COVERAGE

Choose **only ONE** option that best describes your situation. Your choice should be consistent with financial responsibility information provided to a hospital or other entity. Failing to choose an option or choosing more than one will invalidate this form and delay your registration. Department staff cannot advise you on which option to choose. If you have questions regarding an option, consult your personal legal counsel, insurance company or financial institution.

- 1. I have obtained and will maintain professional liability coverage of at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000 from an authorized insurer under section 624.09, F.S., a surplus lines insurer under section 626.914(2), F.S., the Joint Underwriting Association under section 627.351(4), F.S., a self-insurance plan under section 627.357, F.S., or a risk retention group under section 627.942, F.S.
- 2. I have obtained and will maintain an unexpired irrevocable letter of credit or escrow account as defined by Chapter 675, F.S. which is in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000.

MEDICAL MALPRACTICE INSURANCE

Section 456.47(4)(h), F.S., requires the Department of Health to publish the medical malpractice insurance provider and policy limits, including whether the policy covers claims in Florida, of all out-of-state telehealth providers on its website.

1. List your medical malpractice insurance provider:

Insurance Provider: _____

2. List the policy limits of liability:

Policy Limits: _____

3. Does your insurance policy cover claims that arise in Florida? Yes No

I acknowledge this document is being submitted to notify the Department of Health of a change of financial responsibility and/or medical malpractice insurance.

Out-of-State Telehealth Provider's Signature _____ Date _____
You may print out the form and sign it or sign digitally. MM/DD/YYYY