

Confidential QCP DEA Due Diligence Questionnaire

QCP DEA DUE DILIGENCE QUESTIONNAIRE

GENERAL ACCOUNT INFORMATION

Account Code _____

Account Name _____

This Site Address _____

Name/Title of person filling out this form

Phone # where above person can be reached _____

Number of Physician's at this location _____

Name of each Physician and their specialty at this location:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

Initial _____

DOCUMENTATION REQUIRED

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(Attach a separate sheet if necessary)

Copies of DEA licenses for all physicians

Copies of State Board of Pharmacy for all Physicians

Copies of State Physician License for all Physicians

Copy of State Dispensing license, if applicable

Copies of any Board certifications for all Physicians

Copy of any State or Federal certifications that are not listed

Copy of your testing protocol

Copy of your written protocols for practices as it pertains to patients receiving controlled substances.

REQUIRED PRACTICE INFORMATION

1. How many doctors dispense medications to patients in this clinic? _____
2. How many patients does the practice see on average per week? _____
3. How many Workers' Compensation Patients does the practice see per week, on average?

4. Do you dispense narcotics to cash paying patients? Yes _____ No _____
5. If yes, how many cash paying patients do you dispense narcotics per week? _____ (number of patients)
6. How many patients do you see on average per month that are being maintained on Narcotics indefinitely? _____
7. What percentage of patients that you treat with narcotics eventually get to MMI (Maximum Medical Improvement)?

_____ 1 to10% _____ 10 to 25% _____ 25 to50% _____ 50 to 75% _____ 75 to 100%

8. Do you have a drug testing procedure for patients being treated with narcotics?
Yes _____ No _____
(If yes, please include a copy of your testing protocol. If no, would you like QCP to provide to you a copy of a testing protocol that has been recommended to us?) Yes _____ No _____

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9. Do you have a process for terminating patients due to misuse, addiction or diversion issues?

Yes _____ No _____

If yes, please provide details. _____

10. How often does the practice order narcotics?

Weekly _____ Bi-Weekly _____ Monthly _____

11. Do you have a web site for your practice? Yes _____ No _____

If yes, what is the website address? _____

12. Does your website solicit narcotics, or accept orders for narcotics on that site?

Yes _____ No _____

If yes, please explain _____

Please have the Clinic's Head Physician sign and date this, below.)

Signature _____

Date _____

Printed Name of Signatory and Title
