



SummitRe
 Summit Reinsurance Services, Inc.
 www.Summit-Re.com

Request for a Proposal - Provider Excess Loss Coverage

GENERAL INFORMATION:

Legal name of applicant: _____

Principal address: _____

Phone number: _____

Fax number: _____

Tax ID number: _____

CMS provider number: _____

What best describes your organization?

Hospital _____ Medical Group _____ IPA _____ PHO _____

Other (please describe) _____

CONTRACTING INFORMATION:

Provide the most current division of financial responsibility matrix for each managed care organization (MCO) and member type.

ENROLLMENT INFORMATION:

Enrollment (Attach monthly breakouts.)	<u>Commercial</u>	<u>Medicare</u>	<u>Medicaid (Break out by member type.)</u>
3 rd Prior year			
2 nd Prior year			
1 st Prior year			
Current year (Projected)			

TERIARY CARE SERVICES:

Identify tertiary care services for which your organization is financially responsible. Please name the contracted facilities and provide details of the contracted rates by MCO and member type. Please include information about outliers or minimum payment provisions.

Are there any tertiary care services for which your organization does not have contracted rates? If yes, please identify the services and where they're provided.

NON-TERTIARY CARE SERVICES:

Provide a summary of contracted facilities where services are performed and contracted rates.

HISTORICAL COST / UTILIZATION:

<u>Days Per Thousand</u>	<u>Commercial</u>	<u>Medicare</u>	<u>Medicaid</u>
2 nd Prior Year			
1 st Prior Year			
Current Year (Proj)			

<u>Average Cost Per Day</u>	<u>Commercial</u>	<u>Medicare</u>	<u>Medicaid</u>
2 nd Prior Year			
1 st Prior Year			
Current Year (Proj)			

Approximate % of Out of Network or Non-Contracted Services: Hosp _____ Prof _____

Number of contracted PCPs: _____

Number of contracted specialists by specialty type:

	Adult	Pediatric		Adult	Pediatric
AIDS			Neonatal-Perinatal Medicine		
Anesthesiology			Nephrology		
Bariatric Surgery			Neurological Surgery		
Cancer/Medical Oncology			Neurology		
Cancer/Radiation Oncology			Nuclear Medicine		
Cancer/Surgical Oncology			Obstetrics		
Cardiovascular Disease			Orthopaedic Surgery		
Colon & Rectal Surgery			Physical Medicine & Rehab		
Critical Care Medicine			Pulmonary Disease		
Emergency Medicine			Radiology		
Endocrinology, Diabetes & Metabolism			Reproductive Endocrinology & Infertility		
Gastroenterology/Digestive Diseases			Rheumatology		
Geriatric Medicine			Spine Surgery		
Gynecology			Surgery General		
Head & Neck Surgery			Thoracic Surgery/Cardiothoracic Surgery		
Hematology			Transplantation		
Infectious Disease			Vascular Surgery		
Maternal-Fetal Medicine			Wound Care		

UTILIZATION AND CASE MANAGEMENT:

Please describe your utilization and case management programs, including the process for identifying members who are appropriate for case management and the number of case managers on staff.

Describe the measures used to prevent inpatient hospitalization and extended hospital confinements.

MEDICAL MANAGEMENT	CONTACT NAME	PHONE NUMBER
Medical Director		
Director of Medical Management		
Utilization Review		
Case Management		
Transplant Network Vendor		
Disease Management Vendor		
Subrogation Vendor		

CLAIMS:

Name of organization responsible for processing claims: _____

CLAIMS DEPARTMENT	CONTACT NAME	PHONE NUMBER
Primary Claims Contact		

EXCESS CLAIM EXPERIENCE:

Provide claim information for members whose claims exceeded 75% of the lowest specific retention requested in the following format for the prior three years. Identify each period.

Member Name	Member Class	Managed Care Org	Diagnosis or ICD9	Dates of service	Provider Name	Total Charged	Total Paid
J. Doe	Commercial	Aetna		1/1/99-3/1/99	Johns Hopkins	\$123,000	\$92,000

EXCESS LOSS COVERAGE HISTORY:

Please outline your excess loss coverage terms for the last two y ears.

COVERAGE REQUESTED:

Hospital Inpatient Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Outpatient Facility Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skilled Nursing/Extended Care Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home Health Care Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Long Term Acute Care Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ambulance Services	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Organ donor expenses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescription drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Inpatient mental health/chemical dependency services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ procurement expenses	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Outpatient mental health/chemical dependency services	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Physician fee schedule/accumulation basis, if applicable:

Commercial

In-network: _____

Out-of-network: _____

Medicare: _____

Medicaid: _____

Requested Coverage Effective Date: _____

Deductible Options: _____

Inpatient Average Daily Maximum Limitation Options: _____

Coinurance Percentage Options: _____ Transplants ____ All other services

Annual / Lifetime Maximums: _____

Claim Reporting Period: _____

Please outline the structure and extent of any current sub-capitation arrangements as well as for the prior 2 years.

Please disclose any material changes to the risk in the most recent 36 months that the underwriter should note. (E.g. Changes in division of financial responsibility matrices, hospital contracts, etc.):

Checklist of Documents Attached to this Form:

- _____ Tertiary care_hospital contracting arrangements by MCO and member type
- _____ Summary of_non- tertiary care facilities and contracted rates
- _____ Copy of capitation agreement for each MCO – specifically focused on any risk-sharing provisions
- _____ Copies of the division of financial responsibility matrices for all MCOs and member types
- _____ Description of case management processes
- _____ Monthly enrollment breakouts for each year by MCO and member type
- _____ 3 years of claims experience by MCO and member type
- _____ Listing of potential large cases that may be known but may not be reflected in claim dollars
- _____ Copy of current excess loss policy
- _____ Copy of most recent audited financial statement of provider group.

The proposal will be based upon information that you, the undersigned, transmit with this form.

I warrant that this information is accurate to the best of my knowledge and belief, and that no requested information has been omitted or altered.

Signature _____
(Title of Person Requesting Quote)

Date: _____ Phone: _____ Fax: _____

Email: _____

CONFIDENTIALITY:

This document and any attachments are confidential and also may be privileged. If you are not the named recipient, or have otherwise received this document in error, please notify the sender immediately, delete the document, and do not disclose its attachments to any other person, use them for any purpose, or store or copy them in any medium. Thank you for your assistance.

Send the completed form to:

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Fort Wayne, IN 46804
PH: 260-469-3004
FAX: 260-469-3014
E-mail: bfehlhaber@summit-re.com

Broker/Consultant: _____
Commission Amount: _____
Date Quotation Due: _____

Broker of Record: _____(Y/N)_____
Number of Years as BOR: _____
Presentation Date: _____