Provider Excess Request for Proposal

Insurance Effective Date: ________________

Company Name: ____

Address: ____ Phone: ____________________

____ Fax: ______________________

Federal Tax ID#: ________________________________ Date of Request: ___________________

Current Insurer: _______________________________ Proposal Due Date: __________________

EXCESS LOSS COVERAGE – D*ata and Information Request*

1. **Type of Organization -- ___** Hospital ___ Group Practice ___ IPA ___ PHO _____________Other (describe)
2. **Contracting Information –** Provide a copy of the most current risk contract including the division-of-financial-responsibility matrix for each contracted managed care organization (MCO) by member type. For Medicaid members, break out by sub-category. Indicate if there have been significant changes in the last 3 years. Describe any sub-capitation arrangements for the last 3 years.
3. **Coverage Being Requested** – Please list the services for which coverage is being requested (e.g., inpatient hospital services, outpatient facility services, physician services, prescription drugs, etc.). Include requested options for deductibles, average daily maximum limitations, coinsurance, annual/lifetime maximum benefits, and physician fee schedule/accumulation basis, if applicable.
4. **Four Years of Claims Detail** – By insurance year, by line of business, for any member whose claims exceed 50% of the lowest requested deductible. It should also include data for the covered services being requested in the reinsurance proposal (i.e. inpatient only, inpatient and outpatient, or all services). Detail should include:
   a. Line item detail for each claim
   b. Column headings: Member ID (de-identified), Line of Business, Provider Name, Provider Type, Admit Date, Discharge Date, Length of Stay, Place of Service Code, Procedure Code, Revenue Code, DRG, Type of Bill Code, Primary Diagnosis Code, Diagnosis Description, Billed Charges, Allowed Charges, Paid Charges, Paid Date.
   c. <u>Include information on potentially large cases that are known but may not be reflected in the claim report.</u>
5. **Four Years of Member Months** – Provide this information <u>by month by line of business</u> for the past 4 years.
6. **Tertiary Care Services** – Provide the key facility names and contracted rates for tertiary-care services that are your financial responsibility, including information on outliers or minimum payment provisions. Indicate if there are tertiary-care services for which there aren't contracted rates and where those services are rendered.
7. **Non-Tertiary-Care Services** – Provide a summary of contracted facilities and rates.
8. **Historical Utilization/Costs** – Provide days-per-thousand and average-cost-per-day data for the past 3 years by member type.
9. **Non-Network Services** –Provide the percentage of non-network utilization for hospitals and professional services. List any physician specialties that are not in the network.
10. **Medical Management** – Describe the utilization and case management programs, including the process for identifying members for case management and the average case manager caseload. Describe the measure taken to prevent inpatient hospitalizations and extended confinements.

11. **Copy of Current Policy** – Provide a copy of the current excess loss policy and outline the coverage for the previous two years. Also share recovery reports from those years.
12. **Disclose any material changes in the risk in the most recent 24 months that the underwriter should note, i.e. changes in policy benefits, provider contracts, networks, etc.**

I hereby certify that the information provided above is complete and accurate. I understand that in the event Zurich American Insurance issues the insurance coverage being requested, the policy provisions and premium rates will be based on the information provided in this Request for Proposal and any supplementary information. If such information is later found to be incomplete or inaccurate, Zurich may, at its discretion, consider that there has been a material change and may adjust premium rates accordingly.

Completed By: ___________________________ **Title: ___________________________**

Phone: ___________________________ **Fax: ___________________________**

E-Mail: ___________________________

Broker: ___________________________

Broker of Record: Yes ____ [Number of Years as BOR____] No ____

Commission Amount: __________

Please return the completed questionnaire to:

Summit Reinsurance Services, Inc.
6920 Pointe Inverness Way, Suite 140
Fort Wayne, IN 46804
Phone: (260) 469-3000