

## Hospital Capitation Excess Loss - Request For Quotation

### Client Specific Information

Name of Hospital: \_\_\_\_\_

Principal Address: \_\_\_\_\_

Domiciled State (if different): \_\_\_\_\_

Affiliated Hospitals: \_\_\_\_\_

Cost to Charge Ratio: \_\_\_\_\_ HCFA Provider #: \_\_\_\_\_

Average Cost Per Day: \_\_\_\_\_ Self-Funded Employee Benefits:  Yes  No  
 (Total inpatient expenses divided by total inpatient days)

### Enrollment

Please provide monthly breakouts and also the most current division of financial responsibility matrix for each managed care organization.

Managed care organization	Commercial	Medicare	Medicaid

### Tertiary Network Services

Identify medical services for which the hospital is financially responsible, but must refer to other facilities. Please name these facilities and provide their contracted rates.

Service	DRG	Name of facility	Contract basis		
			<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Transplants:	302/480/103/481		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Trauma:	2/485/486		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
NICU:	385-390		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Open heart:	75/104-108/110		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Tracheotomies:	483		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Burns:	941-949		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges

Provide a summary of all contracted facilities and contracted rates.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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### Hospital Cost/Utilization

Average per diem (desired)	Current year (projected)	1 <sup>st</sup> Prior year	2 <sup>nd</sup> Prior year
Commercial:			
Medicare:			
Medicaid:			

Days per thousand	Current year (projected)	1 <sup>st</sup> Prior year	2 <sup>nd</sup> Prior year
Commercial:			
Medicare:			
Medicaid:			

### Medical Management

Describe the mechanism that identifies a Covered Person who requires case management.

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Describe the measures used to prevent inpatient hospitalization.

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Describe the criteria for providing case management services to members.

Please provide the following contact information:

	Contact name	Phone number
Director of medical management:		
Utilization review:		
Case management:		
Transplant network vendor:		
Disease management vendor:		
Subrogation vendor:		

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### Excess Claim Experience

By member classification, provide claim information in the following format for the prior three years. (Identify each period.)

Member name	Unique ID #	Diagnosis or ICD-9	Prognosis	Primary hospital	In/Out of network	Dates of service	Total charges	Total paid

### Requested Coverage

Hospital Inpatient Services:  Yes  No      Hospital Outpatient Services:  Yes  No

Physician Services:  Yes  No

Effective Date: \_\_\_\_\_ Specific Deductible: \_\_\_\_\_

Coinsurance Percentage: \_\_\_\_\_

### Additional Information

Please disclose any material changes to the risk in the most recent 12 months that the underwriter should note, i.e. changes to policy benefits, networks utilized, changes in contracting information, etc.

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### Documents To Attach With This Form

- hospital contracting arrangements
- copies of the division of financial responsibility for all managed care organizations
- claims information

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### Broker of Record

Broker of Record:  Yes  No If yes, number of years as BOR: \_\_\_\_\_

Date Quotation Due: \_\_\_\_\_

Broker Commission (expiring): \_\_\_\_\_

Broker Commission (requested): \_\_\_\_\_

### Signature

The proposal will be based upon information transmitted with this form. The undersigned warrants that he or she has made a diligent effort to verify this information and that, to the best of his or her knowledge and belief, this information accurately represents the facts, and no requested information has been omitted or altered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### 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.

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