PartnerRe

Physician Capitation Excess Loss - Request for Quotation

Client Specific Information

Name of Provider:

Principal Address:

Domiciled State (if different):

Provider's Able to Submit Claims Electronically: ❑ Yes ❑ No

(Please note that the above is a requirement to issuing terms.)

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

Medical Management

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

Describe the measures used to prevent inpatient hospitalization.

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

Network Information

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

Physician Services: ❏ Yes ❏ No

Effective Date: Specific Deductible:

Co-insurance 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.

Utilization

Number of contracted primary care physicians:

How are claims handled outside of network?

Number of contracted specialists:

Approximate percentage of out-of-network or non-contracted physician services:

Network discount:

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Documents To Attach With This Form

- copies of the division of financial responsibility matrices for all managed care organizations
- claims experience
- membership information

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.