PartnerRe

HMO Reinsurance - Request For Quotation

Client Specific Information

Name of Reinsured:

Principal Address:

Domiciled State (if different):

Owned/Affiliated Hospitals:

Tertiary Network Services

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

Non-Tertiary Network Services

Provide a summary of all contracted facilities and contracted rates.

Historical Cost/Utilization

Average per diem (Desired)	**Current year** (projected)	**1st Prior year**	**2nd Prior year**
Commercial:			
Medicare:			
Medicaid:			

Days per thousand	**Current year** (projected)	**1st Prior year**	**2nd Prior year**
Commercial:			
Medicare:			
Medicaid:			

Enrollment

Enrollment	**Current year** (projected)	**1st Prior year**	**2nd Prior year**
Commercial:			
Medicare:			
Medicaid:			

Please attach three years of monthly breakouts.

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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	E-mail address
Director of medical management:			
Utilization review:			
Case management:			
Transplant network vendor:			
Disease management vendor:			
Subrogation vendor:			

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	Dates of service	Total charges	Total paid

Requested Coverage

Hospital Inpatient Services:	☐ Yes ☐ No	Hospital Outpatient Services:	☐ Yes ☐ No
Physician Services:	☐ Yes ☐ No	Conversion Coverage:	☐ Yes ☐ No
Insolvency Coverage:	☐ Yes ☐ No	If Yes, Limits Required:	
Effective Date:		Specific Deductible:	
Coinsurance Percentage:			

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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.

Documents To Attach With This Form

- provider contracts
- membership service agreements
- last annual NAIC financial state and most recent quarterly filing
- claims information by membership type (prior four years)
- enrollment information by membership type (prior four years)
- historical and current average cost per day x days per thousand by membership type

Broker of Record

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

Date Quotation Due:

Broker Commission (expiring):

Broker Commission (requested):

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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

PartnerRe America Insurance Company
199 Fremont Street, 11th Floor • San Francisco, California 94105 • Tel. 1 415 354 1551 • Fax. 1 415 354 1590 • www.PartnerRe.com • underwritinghealth@partnerre.com