PartnerRe

Claims Administrator Questionnaire

CAQ0719

Thank you for completing our Claims Administrator Questionnaire. This document is unique to PartnerRe America Insurance Company.

PartnerRe's mission is built on collaboration with all its stop loss clients. We recognize that every Administrator is different. By completing this document you will help us understand how your organization differentiates itself from others as well as enable us to have a better understanding of your distinct services. This shared information is one step toward gaining a better mutual understanding of your strengths and services.

Our success is your success when it comes to our mutual Policyholders. When possible, we will engage with you to find solutions that optimize financial outcomes of Policyholder customers.

General Information

BUSINESS PROFILE

Full legal name of firm: _____

Corporate address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

Tax Identification Number: _____

List other companies in which you have a financial interest. *(i.e., insurance companies, PPOs, HMOs, MGUs, brokerage firms, etc.)*

Has your business changed names and/or used a dba or operated under an assumed name? ☐ Yes ☐ No *If yes, please explain.*

Claims

Confirm the following information is provided when submitting a claim to PartnerRe:

Proof of Eligibility	❒ **Provided**
Claimant's unique identification number	
Claimant's first and last name	
Claimant's date of birth	
Claimant's effective date of coverage	
Claimant's coverage status	
Name of the health plan – PPO, HMO etc.	
Claimant's termination date, if applicable	
Proof of Loss	❒ **Provided**
Subscriber's name	
Subscriber's unique identification number	
Claim or reference number	
Dates of service	
Provider's name	
Provider type – (in or out-of-network)	
Procedure code (CPT, HCPCS, revenue codes and modifiers)	
Units	
Billed amount	
Paid amount	
DRG code, if applicable	
Diagnosis code	
Place of service code (Standard CMS POS code)	
Type of bill – field locator four on UB04	
Two digit discharge code – field locator on UB04	
Claim Services – when relevant	❒ **Provided**
Documentation of other insurance coverage investigation	
Medicare effective date, as well as the reason for Medicare enrollment	
Documentation of pre-existing condition investigation or certificate of creditable coverage	
Employee work status, including explanation of how coverage was maintained while the employee was not actively at work – may include COBRA election forms and proof of COBRA payments; leave of absence details, total disability determination, etc.	
Supporting Documentation	❒ **Provided**
Copies of pre-authorization and/or hospital pre-certification, etc.	
Case management progress reports	
Copy of UB04 for any hospital claims with paid charges exceeding $500,000	
Itemized bills for any hospital confinement with paid charges exceeding $1,000,000	

Reporting

Provide contact information for key personnel involved in generating and submitting monthly carrier reports/***PULSE*** + Plus™ Report.

Name	Title	Phone	E-mail

Do you have the ability to provide large claim notification based on diagnosis? ☐ Yes ☐ No *If no, please explain.*

Will you abide by the Reporting Requirements as outlined in PartnerRe's Excess Loss Insurance Policy? ☐ Yes ☐ No

Describe your procedure for early notification of potentially large/catastrophic claims to the carrier:

Networks

Provide information for each network utilized. *Please include any wrap networks.*

Network Name	Specialty	Percentage of Claims with Network Discount Applied	Average Provider Savings	Average Hospital Savings	In-Network Utilization Provider	In-Network Utilization Hospital

If the wrap network you utilize only affords a 5-10% discount, do you accept it? ☐ Yes ☐ No *If no, please explain.*

Explain your out-of-network negotiation process.

Do any PPO networks apply multiple surgery, assistant surgery, etc. reductions to pricing? ☐ Yes ☐ No *If no, please explain.*
(Please provide network specific answers.)

How frequently do you update network discounts? _____

Medical Management and Cost Containment

Provide contact information for key personnel involved in generating cost containment reports if different from the reporting contact:

Name	Title	Phone	E-mail

Describe how you integrate utilization management, complex case management, disease management and cost containment services:

Describe what triggers a referral to case management for review:

MEDICAL MANAGEMENT SERVICES

Provide the following information:

Individual responsible for service providers/vendors:

Name	Contact Information

Service	Internal Yes/No	Vendor Name and Contact Information
Utilization review/Concurrent review		
Case management		
Complex case management		
Transplants		
Oncology		
Neonatology		
High risk maternity management		
Chronic kidney disease		
ESRD (pre/active dialysis)		
Dialysis		
Heart disease		
Specialty pharmacy		

Do you make all medical management services available to every stop loss customer? ☐ Yes ☐ No *If no, please explain.*

Pharmacy Benefit Manager

Provide the following information:

Contact Name	Title	Phone	Email

PBM Name	Pharmaceutical Data Integrated into Case Management Utilization Review (Y/N)	Pharmaceutical Data Integrated into Case Management (Y/N)	Individual Claim Data Loaded into System from PBM (Y/N)

What is the process for pre-authorization of high-cost pharmaceuticals? *Please include biomedicals, bioidentical and injectables.*

Do your pharmacy or hospital contracts include negotiated rates for hospital administered (inpatient) prescription drugs?

☐ Yes ☐ No *If yes, are these charges carved out? Please describe.*

Describe how you engage with the stop loss carrier when specialty drugs will incur large losses.

Premium Accounting

Will you provide census and premium funding data electronically? ☐ Yes ☐ No *If no, please explain.*

Will you accept and send ACH financial transactions? ☐ Yes ☐ No *If no, please explain.*

Will you remit premiums to the stop loss carrier net of commissions? ☐ Yes ☐ No *If no, please explain*

Claim Funding

Are the claim funding accounts: ○ general claim, or ○ plan sponsor owned

If applicable, who balances the general fund? Please provide their contact information below.

Name	Title	Years of Experience	Phone	E-mail

Attachments

Please use this checklist and provide the following attachments. (If any items cannot be provided, please explain):

- ☐ Copy of Errors and Omissions policy
- ☐ Copy of Professional Liability policies
- ☐ Copy of current Fidelity bond
- ☐ Copy of TPA, MGA, agency, broker and agent license for each applicable state
- ☐ Premium account flowchart/description
- ☐ Claim account flowchart/description
- ☐ Samples of claims reports available to insurers and/or reinsurers
  (Include 50% report, trigger diagnosis report, pending claims report, large case management notes and an aggregate report. Identify any report for which the policy holder must purchase and/or will not be included in your standard reporting package).
- ☐ Sample plan document

Explanation of above items:

I certify that the information on this application is accurate to the best of my knowledge and belief. I also understand that routine inquiries, including credit inquiries, may be made of any or all of the individuals and firms noted herein as references.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Email: _____ Phone: _____

Mailing Address: _____

Please return this form via secured e-mail to underwritinghealth@partnerre.com.