



Group Medical Information Request Form Supplement

BUSINESS INFORMATION

Name: _____
Address: _____ City: _____
State: _____ Zip: _____
Phone: _____ Date Incorporated (M/Y): _____
Fax: _____ Renewal Date (M/D): _____

INFORMATION NEEDED TO CONDUCT PRELIMINARY FEASIBILITY STUDY

(please note that analysis cannot be completed without all of the requested data)

Complete

Underwriting Requirement

Updated company census (to include; name, date of birth, date of hire, zip code compensation and COBRA status)

Copy of Current Benefit Plan

Most Recent 36 Months Claims Experience

Most Recent 12 Months Large Claim Experience with Prognosis

Current rates (include admin and attachment factors if applicable)

Prior years rates (include admin and attachment factors if applicable)

INFORMATION NEEDED FOR NETWORK COST COMPARISON

Your network must provide the following data in excel format on a per claim basis:

- TIN
- STATE
- BILLED AMOUNT (by line item)
- UB/HCFAs status
- PROCEDURE CODE (for HCFAs)
- IP/OP status (for UBs)
- REVENUE CODE (For UBs)
- DRGs (for UBs)
- # of Days (for IP) **or** To/From Dates of Service
- MODIFIER (If Available - preferred for optimal accuracy)
- UNITS (If Available - preferred for optimal accuracy - will default to 1 if not present)
- PROVIDER NAME, if available

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