



THIRD PARTY CLAIMS ADMINISTRATOR QUESTIONNAIRE

GENERAL

1. Company Name _____
 Address _____
 City _____ State _____ Zip _____
 Telephone () _____ Fax () _____
 Website: _____

2. Sub-Office Locations-
 Address- _____ Phone () _____ Fax () _____

 Address- _____ Phone () _____ Fax () _____

3. Key Contact Names/Titles/phone number/email address-
 Marketing/Sales- _____ Phone() _____ e-mail _____
 Underwriting- _____ Phone() _____ e-mail _____
 Accounting- _____ Phone() _____ e-mail _____
 Claims- _____ Phone() _____ e-mail _____
 Large Case Management- _____ Phone() _____ e-mail _____

4. Is your firm owned by or affiliated with any other organization involved in any area of insurance, managed care or reinsurance? Yes No If yes, please indicate name, relationship, and nature of business.

5. How many years have you been operating as a Third Party Administrator? _____

6. Are you in a state that requires Administrators to be licensed? Yes No If yes, please attach a copy of your license.

7. Have any claims been filed against your Errors & Omissions or Fidelity Bond Policy? Yes No (If yes, please attach details.)

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BUSINESS INFORMATION

8. List Excess Insurers (Stop Loss Carriers) who have granted your firm authorization to administer claims for their self-funded policyholders. (If additional space is needed, please attach.)

<u>Carrier/MGU</u>	<u>% of Inforce Stop Loss Policies</u>
_____	_____
_____	_____
_____	_____
_____	_____

9. Are all Stop Loss markets listed above used in every quote situation? Yes No
If not, please explain criteria for determining the Stop Loss market to use.

10. How many Stop Loss quotes do you expect to send to us during the next 12 months? _____
What percentage do you expect to close? _____

11. Has any insurance company or MGU withdrawn their claims paying authority or TPA approval?
 Yes No (If yes, please attach details.)

12. Have there ever been any law suits or Insurance Department complaints brought against your firm or any of the principals? Yes No (If yes, please attach details.)

CLAIMS AND MANAGED CARE

13. Claims Manager (if different from claim contact named on page 1)

Name _____

Phone _____

E-mail _____

14. Do you ever outsource the claim paying function? Yes No (If yes, please explain.) _____

15. Are you able to transfer claim information electronically through secure lines? Yes No (If yes, please provide the format in which the claim data would be transferred - i.e. excel, access)

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16. Please provide the following vendor information (even if function is performed in-house)
- A. Utilization Review Firm Name _____
 Contact _____ Phone () _____ e-mail _____
- B. Large Case Management Firm Name _____
 Contact _____ Phone () _____ e-mail _____
- C. Dialysis Firm Name _____
 Contact _____ Phone() _____ e-mail _____
- D. Transplant Firm Name _____
 Contact _____ Phone() _____ e-mail _____
- E. Cancer Treatment Firm Name _____
 Contact _____ Phone() _____ e-mail _____
17. How many nurses are staffed for Utilization Review? _____ LCM? _____
18. Is there a Medical Director or Physician available to the non-physician reviewers? Yes No
19. Can you provide notification of potentially catastrophic cases by: Claim amount? Yes No
 Diagnosis Code? Yes No
20. Is the UR firm willing to provide immediate notification and disclose information when catastrophic cases are identified? Yes No (If not, please explain) _____

21. Do you administer claims for any of the following?
- A) Blues Yes No - If so, do you access BlueCard Yes No
- B) United Health Care Yes No
- C) Cigna Yes No
- D) Aetna Yes No
22. Which of the above networks do you do the repricing for? _____
23. Please list networks you use as a secondary source for Out of Network Claims.

ATTACHMENTS

Please attach the following to this completed questionnaire.

- State Administrator License, if applicable.
- Declaration page for Fidelity Bond and E&O coverage's.
- Details of suits filed against Fidelity Bond or E&O coverage's, if any.
- Details of withdrawn claims paying authority, if applicable.
- Details of Insurance Department complaints or law suits, if any.
- Details of on-site TPA audits, if any.
- Sample Plan Document.
- Sample of eligibility listings, and copy of EOB provided to clients.
- Sample of electronic claims submission including eligibility verification and complete claim detail.

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I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE ABOVE INFORMATION IS CORRECT. I ALSO UNDERSTAND THAT AS A MATTER OF PROCEDURE, A ROUTINE INQUIRY MAY BE MADE BY THE COMPANY OF ANY OR ALL OF THE INDIVIDUALS AND FIRMS NOTED ABOVE AS REFERENCES IN THIS QUESTIONNAIRE.

Date _____ Signed _____

Title _____

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