



NEW CLIENT FORM / CLIENT REVISION FORM

Submit Completed Form to:

Client Services

Email: clientservices@medcost.com

Fax Number: 336-774-4208

Phone: 336-760-3090

Please select one: **Addition (New Business)** **Revision (Existing Business)**

INSTRUCTIONS: Please complete all blanks. Missing information may result in a delay of service. In the event of late notification, MedCost will not backdate the effective group more than thirty (30 days).

Date _____ Person Completing Form _____

Phone _____ Email _____

NEW CLIENT INFORMATION

Policy Plan # _____ Company Name _____
(Exactly as shown on ID Card) (Exactly as shown on ID Card)

Associated Companies (Please include the names of subsidiaries, associated companies, or DBAs) _____

Alternate Group Numbers Used _____

Street Address _____

City _____ St _____ Zip _____

PO Box _____ City _____ St _____ Zip _____

Contact Name _____ Contact Phone # _____

Fax # _____ Email _____

Effective Date ____/____/____ Month Plan Year Begins ____ Renewal Month ____ # of Employees ____

Broker Name _____ Company _____

Type of Coverage

Self Insured Fully Insured Other _____

Funding Cycle Daily Weekly Monthly Other _____

Funding cycles should be perfected to ensure providers receive payment within 30 days.

CLAIM ADMINISTRATOR INFORMATION

Claims Administrator Name _____

New Business Contact Person _____ Phone # _____

Benefit/Eligibility Verification Phone # _____
(Exactly as shown on ID Card)

Customer Service Phone # _____ Fax _____
(Exactly as shown on ID Card)

Website _____

Address _____ City _____ St _____ Zip _____

Claims Routing Address _____

City _____ St _____ Zip _____

CLAIM ADMINISTRATOR BILLING INFORMATION

Billing will be based on the employee counts that are reported on this form. Adjustments for revised employee counts will only be retroactive for a maximum of 90 days from the date MedCost is notified of such change.

Billing Contact _____ Billing Contact Phone # _____

Billing Contact Fax # _____ Billing Email _____

Billing Address _____

REINSURANCE CARRIER INFORMATION

Reinsurance Carrier _____ Reinsurance Year _____

Contact Name _____ Phone # _____

KEY COMMUNICATIONS

MedCost notifies customers of any significant changes to the PPO network and periodically sends general updates regarding program changes. Please note that communications are emailed to claim administrators prior to distribution to employers.

Contact Name _____ Email _____

Contact Name _____ Email _____

Contact Name _____ Email _____

Contact Name _____ Email _____

PPO NETWORK INFORMATION

- Complete this section if client has selected the MedCost Preferred PPO
- MedCost Preferred logo must be indicated on the ID Card.
- If adding or revising PPO business, you must provide a copy of the ID Card to MedCost for approval prior to distribution to enrollees.

NOTE: PLEASE SUBMIT A COPY OF THE ID CARD WITH THIS FORM

PPO Network

Note: Please confirm employee counts are accurate. Billing will be based on the employee counts that are reported on this form. Adjustments for revised employee counts will only be retroactive for a maximum of 90 days from the date MedCost is notified of such change.

MedCost Preferred Network (Physician and Hospital)

Effective Date _____ NC - # of employees _____ SC - # of employees _____

Other State - # of employees _____ PEPM Rate _____

- Request access to Missions Hospital. Requires pre-approval from hospital.
- For approved payers, check if group will access the MedCost/Community Health Partners (CHP) network.
- Preprocessing Fee
* An additional cost of \$0.25 PEPM will be applied if MedCost receives both in-network and out-of-network claims.

Benefit Plan Design Information

Benefit Plan Requirements:

- If adding PPO business, the benefit design must include at least 10% coinsurance steering, and the minimum coinsurance level that plan is responsible for cannot be less than 50%.
- Employers who have an annual benefit maximum of less than \$100,000 must be pre-approved for PPO network access no less than 90 days prior to the effective date or the effective date of a benefit plan change for an existing MedCost employer.
- MedCost does not accept plans with referral requirements.
- MedCost will not accept plans with filing limits of less than 180 days.

Previous Payer and PPO Network Accessed: _____

If MedCost was previous network, are you handling run-in? Yes No If yes, how long? _____

Is this a consumer driven health plan (CDHP)? Yes No If yes, please attach the benefit plan summary and employee announcement materials.

Does this plan offer any other PPO, HMO, EPO, or Specialty Carve out Networks? Yes No

If yes, please explain _____

Hospital Benefits

Is there a per visit deductible for emergency room services? Yes Amount \$ _____ No

Is deductible waived if admitted? Yes No

Per Admission Deductible \$ _____ Waived for PPO Hospitals Yes No

Annual Deductible \$ _____ Waived for PPO Hospitals Yes No

Coinsurance Benefit for PPO Hospitals _____% Inpatient _____% Outpatient

Coinsurance Benefit for Non-PPO Hospitals _____% Inpatient _____% Outpatient

NOTES:

- The minimum coinsurance level that plan is responsible for cannot be less than 50% and there must be a minimum of a 10% coinsurance difference between in and out of network providers.
- Plans with annual benefit maximums of less than \$100,000 must be approved for PPO network access no less than 90 days prior to the effective date or the effective date of a benefit plan change for an existing MedCost employer.
- Benefit levels must be paid at the same level for MedCost PPO providers. Please notify MedCost for approval if there is an exception.

Physician Benefits

Primary Care Physician Co-pay for Office Visits Yes Amount \$ _____ No

Specialist Physician Co-pay for Office Visits Yes Amount \$ _____ No

Coinsurance Benefit for PPO Physicians _____% Coinsurance Benefits for Non-PPO Physicians _____%

Are there filing limitations for PPO Providers? Yes No If yes, what is the time frame? _____
MedCost will not accept plans with filing limits of less than 180 days.

Is well-child covered? Yes No If yes, to what age? _____

Is there any preventive care benefit? Yes No If yes, please describe (include limitations/maximums) _____

NOTES:

- The minimum coinsurance level that plan is responsible for cannot be less than 50% and there must be a minimum of a 10% coinsurance difference between in and out of network providers.
- Plans with annual benefit maximums of less than \$100,000 must be approved for PPO network access no less than 90 days prior to the effective date or the effective date of a benefit plan change for an existing MedCost employer.
- Benefit levels must be paid at the same level for MedCost PPO providers. Please notify MedCost for approval if there is an exception.

Does client have Health Management other than MedCost? Yes No

If yes, who? Vendor Name _____ Contact _____
Phone # _____

Does another vendor perform utilization review for psych/substance abuse? Yes No

If yes, who? Vendor Name _____ Contact _____
Phone # _____

Does client have an Employee Assistance Program?

Yes (If yes, please include that portion of the benefit plan design.) No

If yes, who? Vendor Name _____ Contact _____
Phone # _____



If client is NOT using MedCost Health Management please do NOT complete the following pages.

**If client is not using MedCost Health Management do NOT complete this section.
This section should be completed for employers NOT implementing Care Management.**

Selection Options (please check all that apply)

Inpatient Review

Program Effective Date	# of Employees	Rate	Provision Effective Date	Penalty / Incentive Yes/No
				Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No

Describe Penalty/Penalties:

Outpatient Review

Program Effective Date	# of Employees	Rate	Provision Effective Date	Penalty / Incentive Yes/No
				Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No

Describe Penalty/Penalties:

If Outpatient Review was selected, please choose one of the following two choices (select one) and provide a copy of the Summary Plan Document for MedCost approval.

Comprehensive List (O3)

Precertification is required for all elective outpatient surgical procedures performed outside of the physicians' office.

Precertification is required for the following diagnostic procedures performed on an outpatient basis or in the physicians' office:

Varicose Vein Treatment MRI
CT Scan PET Scan

Diagnostic List (O1)

Precertification is required for the following diagnostic procedures

Performed on an outpatient basis or in the physicians' office:

MRI PET Scan
CT Scan

Case Management

Program Effective Date	# of Employees	Rate	Provision Effective Date	Penalty / Incentive Yes/No	Applies To	Type
				Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Member <input type="checkbox"/> Dependent(s) <input type="checkbox"/> or Both	<input type="checkbox"/> Health Plan <input type="checkbox"/> Gift Card <input type="checkbox"/> Vacation <input type="checkbox"/> Monetary Reward <input type="checkbox"/> Flex Spending Acct.
				Incentive <input type="checkbox"/> Yes <input type="checkbox"/> No		

Describe Penalty/Incentive:

** If Case Management was selected, please choose one of the following: Hourly Capitated Outside Referral

CM Authorized Contact _____ Phone # _____

CM Billing Contact _____

CM Billing Contact Address _____

SmartStarts

Program Effective Date	# of Employees	Rate	Provision Effective Date	Penalty / Incentive Yes/No	Type
				Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Health Plan <input type="checkbox"/> Other _____
				Incentive <input type="checkbox"/> Yes <input type="checkbox"/> No	

Describe Penalty/Incentive:

Nurseline

Program Effective Date	# of Employees	Rate

CARE MANAGEMENT PACKAGE OPTIONS (This is only available to approved payers)

Selection Options (check all that apply)

<input type="checkbox"/> *MedCost Care Management Package	Requested Effective Date	# of Employees	Rate
Program Components Include: Inpatient Review Catastrophic Case Management Personal Care Management Buy Up Options: <input type="checkbox"/> Outpatient Review – Diagnostic <input type="checkbox"/> Outpatient Review - Comprehensive <input type="checkbox"/> SmartStarts Maternity Management – High Risk <input type="checkbox"/> Smartstarts Maternity Management - Comprehensive Optional Add on Programs: <input type="checkbox"/> Nurse Advice Line	_____	_____	_____
	_____	_____	_____

*** Note:** There are specific business requirements for implementation of Care Management. A MedCost representative will contact you to begin the implementation process.

HEALTH MANAGEMENT SUPPLIES

On-line PPO directories can be accessed at www.medcost.com. Flyers and payroll stuffers are provided at 120% of the employer’s headcount (at no charge). Supplies exceeding this amount will be subject to a charge.

Item	Quantity	Item	Quantity
Personal Care Management Flyer		Nurse Advice Line Brochure	
Personal Care Management Poster		Nurse Advice Line Flyer	
Outpatient Review Flyer		Nurse Advice Line Poster	
Inpatient Review Flyer		SmartStarts Maternity Management Flyer	
		SmartStarts Maternity Management Poster	

Ship supplies to:

Contact Name _____

Company _____

Address _____

City _____ St _____ Zip _____

Email _____

HEALTH MANAGEMENT ACTIVITY REPORTS

Contact Name _____

Company Name _____

Address _____

City _____ St _____ Zip _____

Email _____

(If additional contact should receive Activity Reports, please indicate below.)

Contact Name _____

Company Name _____

Address _____

City _____ St _____ Zip _____

Email _____

Rev08/06/2010