PartnerRe

Bundled Payments – Request for Quotation

CLIENT SPECIFIC INFORMATION

Name of Provider: _____

Principal Address: _____

Domiciled State (if different): _____

Number of Years with Bundled Payments: _____

Reason if Stopped with Bundled Payments: _____

Current Carrier: _____

Current Rate: _____ Based Upon _____(per procedure, per DRG, other)

MEDICARE BUNDLED PAYMENTS

CMS BPCI Model: _____

Number of Days of Post Acute Care: _____

Winsorize threshold: _____ percentile

COMMERCIAL BUNDLED PAYMENTS

Covered Services: _____

Number of Days of Post Acute Care: _____

Methodology for establishing Bundled budget: _____

_____

Reimbursement/accumulation method for reinsurance purposes: _____

_____

MEDICAID BUNDLED PAYMENTS

Covered Services: _____

Number of Days of Post Acute Care: _____

Methodology for establishing Bundled budget: _____

_____

Reimbursement/accumulation method for reinsurance purposes: _____

_____

REQUESTED COVERAGE

Policy Period: _____

Claims Basis: _____

Are you looking for specific excess of loss coverage? ☐ Yes ☐ No If yes, please indicate preference below:

Specific Deductible: $ _____

Policy Limit: $ _____

Coinsurance: _____ %

PartnerRe

Bundled Payments – Request for Quotation

Are you looking for aggregate coverage? ☐ Yes ☐ No

If yes, please indicate preference below:

■ Attachment Point: _____ % (e.g. 120%)

Policy Limit: $ _____ Coinsurance: _____ %

NETWORK AND POST-ACUTE CARE CONTRACTS

Please provide the following information:

Facilities	Location	Covered DRG Codes

DOCUMENTS TO ATTACH WITH THIS FORM

- For BPCI, CMS DRG data referenced in your BPCI application
- If unavailable or for non-BPCI:

  List of covered DRGs, expected number of procedures, and Bundled Payment target price per facility Bundled Payment contracts

☐ Three years of Bundled claims paid charges listed by policy period, facility, and DRG

☐ CMS BPCI Contract for Medicare coverage or Payer Contract for non-Medicare coverage

ADDITIONAL INFORMATION THAT MAY BE REQUESTED

☐ Staff performing administrative functions (e.g. verifies eligibility, processes claims) and clinical functions (e.g. coordinates care management, provides clinical care)

☐ Network providers' care coordination to achieve the Bundle Payment target price (e.g. medical specialists, nursing professionals, home health care, rehabilitation)

☐ Communication network with Bundled providers

BROKER OF RECORD

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

Date Quotation Due: _____

Broker Commission (requested): _____

Bundled Payments – Request for Quotation

SIGNATURE

This proposal will be based upon the 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

WARNING: This form contains personal and Protected Health Information under HIPAA and may be transmitted only in a HIPAA compliant medium. **DO NOT SEND VIA AN UNSECURED E-MAIL TRANSMISSION**.