PartnerRe

Hospital Capitation Excess Loss - Request For Quotation

CLIENT SPECIFIC INFORMATION

Name of Hospital:

Principal Address:

Domiciled State (if different):

Affiliated Hospitals:

Cost to Charge Ratio: HCFA Provider #:

Average Cost Per Day: Self-Funded Employee Benefits: ❑ Yes ❑ No
(Total inpatient expenses divided by total inpatient days)

ENROLLMENT

Please provide monthly breakouts and also the most current division of financial responsibility matrix for each managed care organization.

Managed care organization	Commercial	Medicare	Medicaid

TERTIARY NETWORK SERVICES

Identify medical services for which the hospital is financially responsible, but must refer to other facilities.
Please name these facilities and provide their contracted rates.

Service	DRG	Name of facility	Contract basis		
Transplants:	302/480/103/481		❑ Per Diem	❑ DRG	❑ Charges
Trauma:	2/485/486		❑ Per Diem	❑ DRG	❑ Charges
NICU:	385-390		❑ Per Diem	❑ DRG	❑ Charges
Open heart:	75/104-108/110		❑ Per Diem	❑ DRG	❑ Charges
Tracheotomies:	483		❑ Per Diem	❑ DRG	❑ Charges
Burns:	941-949		❑ Per Diem	❑ DRG	❑ Charges

Provide a summary of all contracted facilities and contracted rates.

Hospital Capitation Excess Loss - Request For Quotation

HOSPITAL COST/UTILIZATION

Average per diem (desired)	**Current year** (projected)	**1st Prior year**	**2nd Prior year**
Commercial:			
Medicare:			
Medicaid:			

Days per thousand	**Current year** (projected)	**1st Prior year**	**2nd Prior year**
Commercial:			
Medicare:			
Medicaid:			

MEDICAL MANAGEMENT

Describe the mechanism that identifies a Covered Person who requires case management.

Describe the measures used to prevent inpatient hospitalization.

Describe the criteria for providing case management services to members.

Please provide the following contact information:

	Contact name	**Phone number**
Director of medical management:		
Utilization review:		
Case management:		
Transplant network vendor:		
Disease management vendor:		
Subrogation vendor:		

PartnerRe

Hospital Capitation Excess Loss - Request For Quotation

EXCESS CLAIM EXPERIENCE

By member classification, provide claim information in the following format for the prior three years. (Identify each period.)

Member name	Unique ID #	Diagnosis or ICD-10	Prognosis	Primary hospital	In/Out of network	Dates of service	Total charges	Total paid

REQUESTED COVERAGE

Hospital Inpatient Services: ❑ Yes ❑ No Hospital Outpatient Services: ❑ Yes ❑ No

Physician Services: ❑ Yes ❑ No

Effective Date: Specific Deductible:

Coinsurance Percentage:

ADDITIONAL INFORMATION

Please disclose any material changes to the risk in the most recent 12 months that the under should note, i.e. changes to policy benefits, networks utilized, changes in contracting information, etc.

DOCUMENTS TO ATTACH WITH THIS FORM

- Hospital contracting arrangements
- Copies of the division of financial responsibility for all managed care organizations
- Claims information

Hospital Capitation Excess Loss - Request For Quotation

BROKER OF RECORD

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

Date Quotation Due:

Broker Commission (expiring):

Broker Commission (requested):

SIGNATURE

The proposal will be based upon 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

This document and any attachments are confidential and also may be privileged. If you are not the named recipient, or have otherwise received this document in error, please notify the sender immediately, delete the document, and do not disclose its attachments to any other person, use them for any purpose, or store or copy them in any medium. Thank you for your assistance.

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.**