McPhee
& ASSOCIATES, INC.
Specialty Insurance Services

REQUEST FOR PROPOSAL

CAPITATED PROVIDER
STOP-LOSS QUESTIONNAIRE
www.McPheeAssociates.com

THE INFORMATION CONTAINED IN THIS REQUEST AND TRANSMITTED WITH IT IS TO BE USED ONLY FOR THE UNDERWRITING OF STOP-LOSS INSURANCE. IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND WILL NOT BE RELEASED TO ANY PARTIES OTHER THAN THE APPROPRIATE INSURANCE CARRIERS FOR THE PURPOSE OF GETTING QUOTES.

GENERAL INFORMATION

Name of Medical Group	
Street Address	
City, State, Zip	
Contact	
Title	
Telephone Number	
Fax Number	
E Mail Address	

Name of Hospital	
Street Address	
City, State, Zip	
Contact	
Title	
Telephone Number	
Fax Number	
E Mail Address	

COVERAGE DESIRED

REQUESTED EFFECTIVE DATE:

		Hospital		Physician		Both		
Physicians Stop-Loss Deductible:		$15,000		$20,000		$25,000		Other:___________
Hospital Stop-Loss Deductible:		$75,000		$100,000		$125,000		Other:___________
Co-Insurance:		80%		90%				Other:___________

MAXIMUM ELIGIBLE EXPENSE

PHYSICIANS:	
IN-NETWORK (CONTRACTED PROVIDERS	
Option A	_____________% RBRVS of __________Year
Option B	Other (Specify):
OUT-OF-NETWORK (NON-CONTRACTED PROVIDERS	
Option A	_____________% RBRVS of __________Year
Option B	Amount Paid
Option C	Other (Specify):
HOSPITAL:	
IN-NETWORK (CONTRACTED) PROVIDERS	
Option A:	$___________Med./Surg. $___________NICU/CCU/ICU $___________TCU
Option B:	$___________Average Per Diem
Option C:	___________% Percentage of Charges to $____________ Average Per Diem
Option D:	Other (Specify):
OUT-OF-NETWORK (NON-CONTRACTED) PROVIDERS	
Option A:	$___________Average Per Diem
Option B:	Amount Paid
Option C:	Other (Specify):

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CAPITATION CONTRACTS

Please provide the following information regarding the capitation contracts you have with various Managed Care Organization. Use the back of this form or attach additional sheets as necessary.

HMO				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare:	Medi-Medi:
	Medicaid:	SPD:	Other (Specify):	

HMO				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare:	Medi-Medi:
	Medicaid:	SPD:	Other (Specify):	

HMO				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare:	Medi-Medi:
	Medicaid:	SPD:	Other (Specify):	

HMO				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare:	Medi-Medi:
	Medicaid:	SPD:	Other (Specify):	

HMO				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare:	Medi-Medi:
	Medicaid:	SPD:	Other (Specify):	

HMO				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare:	Medi-Medi:
	Medicaid:	SPD:	Other (Specify):	

***Please advise if you are responsible for self-referrals on POS members.**

ENROLLMENT

CURRENT ENROLLMENT AS OF ____________________(Provide Date)

MEMBERS		HMO #1		HMO #2		HMO #3		HMO #4	
Commercial	POS								
Exchange	Medi-Medi								
Medicare	SNP								
Medicaid AFDC	Non-AFDC								
Cal. SPD Over 21	Under 21								
Other Specify):______________									

MEMBER MONTHS FOR THE ANNUAL PERIOD FROM ____________ TO ____________

Current Year MEMBERS		HMO #1		HMO #2		HMO #3		HMO #4	
Commercial	POS								
Exchange	Medi-Medi								
Medicare	SNP								
Medicaid AFDC	Non-AFDC								
Cal. SPD Over 21	Under 21								
Other Specify):______________									

Previous Year MEMBERS		HMO #1		HMO #2		HMO #3		HMO #4	
Commercial	POS								
Exchange	Medi-Medi								
Medicare	SNP								
Medicaid AFDC	Non-AFDC								
Cal. SPD Over 21	Under 21								
Other Specify):______________									

2 Years Ago MEMBERS		HMO #1		HMO #2		HMO #3		HMO #4	
Commercial	POS								
Exchange	Medi-Medi								
Medicare	SNP								
Medicaid AFDC	Non-AFDC								
Cal. SPD Over 21	Under 21								
Other Specify):______________									

3 Years Ago MEMBERS		HMO #1		HMO #2		HMO #3		HMO #4	
Commercial	POS								
Exchange	Medi-Medi								
Medicare	SNP								
Medicaid AFDC	Non-AFDC								
Cal. SPD Over 21	Under 21								
Other Specify):______________									

Projected Next Year MEMBERS		HMO #1		HMO #2		HMO #3		HMO #4	
Commercial	POS								
Exchange	Medi-Medi								
Medicare	SNP								
Medicaid AFDC	Non-AFDC								
Cal. SPD Over 21	Under 21								
Other Specify):______________									

PROVIDER INFORMATION

	NUMBER UNDER CONTRACT TO YOU	NUMBER OF PHYSICIANS THAT ARE CAPITATED	NUMBER OF MEMBERS CAPITATED
Physicians – Primary			
Physicians – Specialty			
Hospitals			
Anesthesiologists			
Oncologists			
Cardiologists			
Neonatologists			

PHYSICIANS ONLY	Listed contracted specialties and their arrangements
Cardiologists	
Neonatologists	
Oncologists	
Anesthesiologists	
Neurologists	
List any other specialists with special arrangements. Attach additional sheets if necessary.	

HOSPITALS ONLY	List contracted hospitals with their per diem or discount arrangement. *Include outlier (stop-loss) arrangements, if any.*			
NAME	CARDIAC	MED./SURG.	ICU	NICU

If there are any special arrangements for Trauma, Burn, Transplants, Oncology, Neurology, or Level 4 NICU, please provide data:

UTILIZATION AND CONTROL PROCEDURES

Please provide details on utilization review procedures and large case management arrangements used by your facility/organization to control costs. Please use back of form or attach separate sheets as needed.

1. Control over utilization:

2. Prevent excess length of hospital in-patient stays:

3. Assure quality medical service to members:

4. Provide meaningful peer review:

5. Bed Days Per Thousand: Commercial: Medicare: Medicaid:
POS: Other (Specify):

STOP-LOSS EXPERIENCE

Please provide the following information on the current reinsurance arrangement(s) you have on your current capitation contracts. Complete for each different reinsurance arrangement in force. Use back of form or attach separate sheets as needed.

Name of Present Carrier		
Current Contract Period		
Current Coverage	Deductible: $	Co-Insurance: %
	Maximum Benefit: $	Rates: $ Per member per month
	SUBMIT A COPY OF THIS COVERAGE WITH THIS FORM	

The information contained in this request and transmitted with it constitutes the data upon which a proposal will be based. In submitting this proposal request, the undersigned warrants that he or she has made a diligent effort to verify the information contained herein; and that, to the best of their knowledge and belief, such information accurately represents the facts; and that no pertinent information has been omitted or altered.

Signature	**Date**
Title	**Company**

DOCUMENTS TO ACCOMPANY THIS APPLICATION

The following documents and information are required in order to process your request. Please check all items attached.

- Copy of capitation agreement(s) with HMO(s) or **division of responsibility matrix (DoFR)**.
- Physicians: Fee schedule if other than RBRVS.
- Hospitals: Copy of Hospital Inventory reflecting the services available at your facility.
- Please include all enrollees from the current and past three years who:

1. Have reached 75% or more of the deductible requested;
2. Are in the hospital on the date indicated and are expected to exceed 75% of the deductible requested;
3. Are under treatment or a serious condition which can be expected to exceed 75% of the deductible requested in total expenses before the medical problem is resolved; or
4. Have been identified as candidates for a major operation or extensive care.

Show for each of the above:
1. Name or I.D. number
2. Diagnosis/prognosis
3. Expenses incurred to date
4. Expected final expense total
5. Currently hospitalized
6. If Hospital Coverage is to be quoted, if possible, provide a breakdown of Med./Surg. days, ICU days and SNF and Home Health and Rehab. Facility Days.

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