McPhee & ASSOCIATES, INC.
Managed Care Insurance

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	

If this is an MSO or other type of entity, please provide the data under the section for Medical Group and identify type of entity. If an MSO, please provide name and address of the medical groups to be covered.

COVERAGE DESIRED

REQUESTED EFFECTIVE DATE:

Physicians Stop-Loss Deductible:	☐	$20,000	☐	$25,000	☐	$30,000	☐	Other:_____
Hospital Stop-Loss Deductible:	☐	$100,000	☐	$125,000	☐	$150,000	☐	Other:_____
Global (Hospital & Physician Combined) Stop-Loss Deductible:	☐		☐		☐		☐	

Coinsurance:	☐	80%	☐	90%	☐	Other:_____

MAXIMUM ELIGIBLE EXPENSE

PHYSICIANS:	
IN-NETWORK (CONTRACTED PROVIDERS)	
_____% RBRVS of _____Year	
Provide conversion factor of Anesthesiology if different than above: _____	
List any specialists/providers paid other than above:	
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):

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 1				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	SNP:
	Medi-Medi (Dual):	Medicaid:	SPD:	Other (Specify):

HMO 2				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	SNP:
	Medi-Medi (Dual):	Medicaid:	SPD:	Other (Specify):

HMO 3				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	SNP:
	Medi-Medi (Dual):	Medicaid:	SPD:	Other (Specify):

HMO 4				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	SNP:
	Medi-Medi (Dual):	Medicaid:	SPD:	Other (Specify):

HMO 5				
Street Address				
City, State, Zip				
Effective Date	Commercial/POS:	Exchange:	Medicare Advantage:	SNP:
	Medi-Medi (Dual):	Medicaid:	SPD:	Other (Specify):

ENROLLMENT

CURRENT ENROLLMENT AS OF _____ (Provide Date)

HMO	Commercial	POS	Exchange	Medicare Advantage	Medicare SNP	Medi-Medi (Dual)	Medicaid	SPD
1								
2								
3								
4								
5								

CURRENT YEAR MEMBERS MONTHS FOR ANNUAL PERIOD FROM _____ TO _____

HMO	Commercial	POS	Exchange	Medicare Advantage	Medicare SNP	Medi-Medi (Dual)	Medicaid	SPD
1								
2								
3								
4								
5								

PREVIOUS YEAR MEMBER MONTHS FOR ANNUAL PERIOD FROM _____ TO _____

HMO	Commercial	POS	Exchange	Medicare Advantage	Medicare SNP	Medi-Medi (Dual)	Medicaid	SPD
1								
2								
3								
4								
5								

2 YEARS AGO MEMBER MONTHS FOR ANNUAL PERIOD FROM _____ TO _____

HMO	Commercial	POS	Exchange	Medicare Advantage	Medicare SNP	Medi-Medi (Dual)	Medicaid	SPD
1								
2								
3								
4								
5								

3 YEARS AGO MEMBER MONTHS FOR ANNUAL PERIOD FROM _____ TO _____

HMO	Commercial	POS	Exchange	Medicare Advantage	Medicare SNP	Medi-Medi (Dual)	Medicaid	SPD
1								
2								
3								
4								
5								

PROJECTED FOR NEXT YEAR

HMO	Commercial	POS	Exchange	Medicare Advantage	Medicare SNP	Medi-Medi (Dual)	Medicaid	SPD
1								
2								
3								
4								
5								

PROVIDER INFORMATION

	NUMBER UNDER CONTRACT TO YOU	NUMBER OF MEMBERS CAPITATED	List Specialists Arrangements*
Physicians – Primary			
Physicians – Specialty			
Hospitals			
Anesthesiologists*			
Oncologists*			
Cardiologists*			
Neonatologists*			
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)**.

- Please include all enrollees from the current and past three years who:

  1. Have reached 50% or more of the deductible requested;
  2. Are in the hospital on the date indicated and are expected to exceed 50% of the deductible requested;
  3. Are under treatment or a serious condition which can be expected to exceed 50% of the deductible requested in total expenses before the medical problem is resolved; or
  4. Have been identified as candidates for a major operation, extensive care on awaiting for evaluation or on a transplant list.

  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.