NEW CLIENT FORM / CLIENT REVISION FORM

Submit Completed Form to:
Client Services
Email: clientservices@medcost.com
Fax Number: 336-970-2111
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: (Include names of subsidiaries, associated companies, or DBAs.) ______________________________________

Alternate Group Numbers Used: ____

Street Address: ____

City:___________________________________ State:________ Zip:__________

PO Box:_____________________City:______________________________State: _______ Zip:______________

Addresses of additional locations accessing the MedCost Network if different from above:

Street Address:____

State: ___________________ Zip________________ County____

Contact Name: ____________________________________ Contact Phone #:______________________________

Fax #: ____ Email:____

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

Broker Name: ___________________________________ Company: ______________________________________

Address: _________________________________ City: ____________________ State: ______ Zip: ___________

Phone Number: ______________________ Email Address: ____

Type of Coverage

❑ Self-Insured ❑ Fully-Insured

Funding Cycle ❑ Daily ❑ Weekly ❑ Monthly ❑Other________________________________

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

CLAIM ADMINISTRATOR INFORMATION

Claim 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: ______________ State: ______ Zip: ________

Claims Routing Address: ________________________________

City: ____________________ State: _______ Zip: ______________

CLAIM ADMINISTRATOR BILLING INFORMATION

Billing Contact: ____________________ Billing Contact Phone #: ______________

Billing Contact Fax #: ______________ Billing Email: ____________________

Billing Address: ____________________ City: ______________ State: ______ Zip: ________

REINSURANCE CARRIER INFORMATION

Reinsurance Carrier: ____________________ Reinsurance Year: ________

Contact Name: ____________________ Phone #: ______________

Email Address:________________________________

Street Address:____________________City:______________State:________Zip:________

NETWORK INFORMATION

- ➢ Complete this section if client has selected the MedCost Network.
- ➢ MedCost logo must be indicated on the ID Card.
- ➢ ***If adding or revising network 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 AND SUMMARY OF BENEFIT PLAN DESIGN WITH THIS FORM

MedCost 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 Network (Physician and Hospital)

Effective Date: ______________________ NC - # of employees: _________ SC - # of employees: _________

Other State - # of employees: _________________ PEPM Rate: _____________________

❑ 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 MedCost Network business, the benefit design must include at least 10% coinsurance steerage, and the minimum coinsurance level that the plan is responsible for cannot be less than 50%.
- Employers who have an annual benefit maximum of less than $100,000 must be approved for MedCost Network access no less than 90 days prior to the effective date. A benefit plan change for an existing MedCost employer also must be approved no less than 90 days prior to the effective date.
- MedCost does not accept plans with referral requirements.
- MedCost will not accept plans with filing limits of less than 180 days.
- MedCost will not accept plans with Reference Based Pricing.
- Benefit levels must be paid at same level for MedCost Network providers. Please notify MedCost for approval if there is an exception.

Previous Payer and PPO Network Accessed: ____
Reason group made change:____
If MedCost was previous network, are you handling run-in? ❑ Yes ❑ No If yes, how long? _____________

Does this plan have any limited benefits? ❑ Yes ❑ No If yes, please explain. _________________________
____

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

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 Benefit 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).

____

MEDCOST HEALTH MANAGEMENT INFORMATION

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.

MEDCOST HEALTH MANAGEMENT PRODUCT OPTIONS

If client is not using MedCost Health Management, do NOT complete this section.

Selection Options: (Check all that apply.)

❑ Inpatient Review

Program Effective Date	# of Employees	Rate	Provision Effective Date	Penalty / Incentive Yes/No
				Penalty ❑Yes ❑No

Describe Penalty:

❑ Outpatient Review

Program Effective Date	# of Employees	Rate	Provision Effective Date	Penalty / Incentive Yes/No
				Penalty ❑Yes ❑No

Describe Penalty:

If Outpatient Review was selected, choose one of the following two options and provide a copy of the Summary Plan Document for MedCost approval.

❑ Comprehensive List (O3)	❑ Diagnostic List (O1)
Precertification is required for all elective outpatient surgical procedures performed outside of the physician's 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	Precertification is required for the following diagnostic procedures performed on an outpatient basis or in the physician's office: MRI PET Scan CT Scan

❑ Catastrophic Case Management

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

Describe Penalty/Incentive:

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 ❑Yes ❑No Incentive ❑Yes ❑No	❑Health Plan ❑Other __________

Describe Penalty/Incentive:

❑ Nurse Advice Line

Program Effective Date	# of Employees	Rate

EMPLOYEE WELLNESS RESOURCES

MedCost nurses would like to ensure they refer members to wellness programs offered by employers. When this information is provided to us, MedCost will be able to generate reporting that shows the number of referrals made into each employer's program(s).

You may submit an attachment that provides this information. ☐ Attached

Program Name: ____

Effective Date of Program: ____________________ Termination Date of Program: _____________________

Program Contact: _______________________________________ Phone #: __________________________

Locations Eligible: ____

Program Cost: ____

General Description of Program: ____