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**NEW CLIENT FORM / CLIENT REVISION FORM**

**Submit Completed Form to:**

Client Services

Email: [clientservices@medcost.com](mailto: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: Click arrow to select date. Person Completing Form: Click to enter text.

Phone: Click to enter text. Email: Click to enter text.

**NEW CLIENT INFORMATION**

Policy Plan #: Click to enter text. Company Name: Click to enter text.

**(Exactly as shown on ID Card) (Exactly as shown on ID Card)**

Associated Companies: (Include names of subsidiaries, associated companies, or DBAs.) Click to enter text.

Alternate Group Numbers Used: Click to enter text.

Street Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

PO Box: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

Addresses of additional locations access the MedCost Network if different from above:   
Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

Contact Name: Click to enter text. Contact Phone #: Click to enter text. Fax #: Click to enter text.

Email: Click to enter text.

Effective Date: Click arrow to select date. Month Plan Year Begins: Enter month. Renewal Month: Enter month. # of Employees: Click to enter text.

Broker Name: Click to enter text. Company: Click to enter text.

**Type of Coverage**

Self-Insured  Fully-Insured  Other Click to enter text.

Funding Cycle  Daily  Weekly  Monthly Other Click to enter text.

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

**CLAIM ADMINISTRATOR INFORMATION**

Claim Administrator Name: Click here to enter text.

New Business Contact Person: Click to enter text. Phone #: Click to enter text.

Benefit/Eligibility Verification Phone #: Click to enter text.

**(Exactly as shown on ID Card)**

Customer Service Phone #: Click to enter text. Fax: Click to enter text.

**(Exactly as shown on ID Card)**

Website: Click to enter text.

Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

Claims Routing Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

**CLAIM ADMINISTRATOR BILLING INFORMATION**

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.

Billing Contact: Click to enter text. Billing Contact Phone #: Click to enter text.

Billing Contact Fax #: Click to enter text. Billing Email: Click to enter text.

Billing Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

**REINSURANCE CARRIER INFORMATION**

Reinsurance Carrier: Click to enter text. Reinsurance Year: Click to enter text.

Contact Name: Click to enter text. Phone #: Click to enter text.

Street Address: Click to enter text. City: Click to enter text. State: Click to enter text. Zip: Click to enter text.

**KEY COMMUNICATIONS**

MedCost notifies customers of any significant changes to the MedCost Network and periodically sends general updates regarding program changes. Please note that communications are emailed to claim administrators prior to distribution to employers.

Contact Name: Click to enter text. Email: Click to enter text.

Contact Name: Click to enter text. Email: Click to enter text.

Contact Name: Click to enter text. Email: Click to enter text.

Contact Name: Click to enter text. Email: Click to enter text.

**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 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: Click arrow to select date. NC - # of employees: Click to enter text. SC - # of employees: Click to enter text.

Other State - # of employees: Click to enter text. PEPM Rate: Click to enter text.

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.

Previous Payer and PPO Network Accessed: Click to enter text.  
Reason group made change: Click to enter text.

If MedCost was previous network, are you handling run-in? Yes  No If yes, how long? Click to enter text.

Does this plan have any limited benefits? Yes No If yes, please explain. Click to enter text.

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: Click to enter text.

**Hospital Benefits**

Is there a per visit deductible for emergency room services?  Yes Amount: $Click to enter text.  No

Is deductible waived if admitted?  Yes  No

Per Admission Deductible: $Click to enter text. Waived for PPO Hospitals?  Yes  No

Annual Deductible: $Click to enter text. Waived for PPO Hospitals?  Yes  No

Coinsurance Benefit for PPO Hospitals: Click to enter text.% Inpatient Click to enter text.% Outpatient

Coinsurance Benefit for Non-PPO Hospitals: Click to enter text.% Inpatient Click to enter text.% Outpatient

**NOTES:**

* The minimum coinsurance level that the plan is responsible for cannot be less than 50%, and there must be a minimum of a 10% coinsurance difference between in-network and out-of-network providers.
* Plans with annual benefit maximums 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.
* Benefit levels must be paid at the same level for MedCost Network providers. Please notify MedCost for approval if there is an exception.

**Physician Benefits**

Primary Care Physician Co-pay for Office Visits?  Yes Amount: $Click to enter text.  No

Specialist Physician Co-pay for Office Visits?  Yes Amount: $Click to enter text.  No

Coinsurance Benefit for PPO Physicians: Click to enter text. % Coinsurance Benefit for Non-PPO Physicians: Click to enter text.%

Are there filing limitations for PPO Providers? Yes  No If yes, what is the time frame? Click to enter text.

**MedCost will not accept plans with filing limits of less than 180 days.**

Is well-child covered?  Yes  No If yes, to what age? Click to enter text.

Is there any preventive care benefit?  Yes  No If yes, please describe (include limitations/maximums). Click to enter text.

**NOTES:**

* The minimum coinsurance level that the plan is responsible for cannot be less than 50%, and there must be a minimum of a 10% coinsurance difference between in-network and out-of-network providers.
* Plans with annual benefit maximums 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.
* Benefit levels must be paid at the same level for MedCost Network providers. Please notify MedCost for approval if there is an exception.

**MEDCOST HEALTH MANAGEMENT INFORMATION**

Does client have Health Management other than MedCost?  Yes  No

If yes, who? Vendor Name: Click to enter text. Contact: Click to enter text.

Phone #: Click to enter text.

Does another vendor perform utilization review for psych/substance abuse?  Yes  No

If yes, who? Vendor Name: Click to enter text. Contact: Click to enter text.

Phone #: Click to enter text.

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: Click to enter text. Contact: Click to enter text.

Phone #: Click to enter text.



**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. This section should be completed only for employers that are NOT implementing the Care Management Package.**

Selection Options: (Check all that apply.)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Inpatient Review** | | | | | | | | | | | | | | | | | | | | | |
| **Program Effective Date** | | | | **# of Employees** | | | | | **Rate** | | | | **Provision Effective Date** | | | | | | **Penalty / Incentive Yes/No** | | |
| Click arrow to enter date. | | | | Click here to enter text. | | | | | Enter rate. | | | | Click arrow to enter date. | | | | | | Penalty Yes No | | |
| **Describe Penalty:** Click here to enter text. | | | | | | | | | | | | | | | | | | | | | |
| **Outpatient Review** | | | | | | | | | | | | | | | | | | | | | |
| **Program Effective Date** | | | | **# of Employees** | | | | | **Rate** | | | | **Provision Effective Date** | | | | | | **Penalty / Incentive Yes/No** | | |
| Click arrow to enter date. | | | | Click here to enter text. | | | | | Enter rate. | | | | Click arrow to enter date. | | | | | | Penalty Yes No | | |
| **Describe Penalty:** Click here to enter text. | | | | | | | | | | | | | | | | | | | | | |
| If Outpatient Reviewwas 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 physicians’ office. | | | | | | | | | | | | | | Precertification is required for the following diagnostic procedures performed on an outpatient basis or in the physician’s office: | | | | | | | |
| Precertification is required for the following diagnostic procedures | | | | | | | | | | | | | |  | | | | | | | |
| performed on an outpatient basis or in the physician’s office: | | | | | | | | | | | | | | MRI PET Scan | | | | | | | |
|  | | | | | | | | | | | | | | CT Scan | | | | | | | |
| Varicose Vein Treatment MRI | | | | | | | | | | | | | |  | | | | | | | |
| CT Scan PET Scan | | | | | | | | | | | | | |  | | | | | | | |
| **Catastrophic Case Management** | | | | | | | | | | | | | | | | | | | | | |
| **Program Effective Date** | **# of Employees** | | | | **Rate** | | | **Provision Effective Date** | | | | **Penalty / Incentive Yes/No** | | | | | **Applies To** | | | | **Type** |
| Click arrow to enter date. | Click here to enter text. | | | | Enter rate. | | | Click arrow to enter date. | | | | Penalty  Yes  No | | | | | Member  Dependent(s)  or Both | | | | Health Plan  Gift Card  Vacation  Monetary Reward  Flex Spending Acct. |
| Incentive  Yes  No | | | | |
| **Describe Penalty/Incentive:** Click here to enter text. | | | | | | | | | | | | | | | | | | | | | |
| \*\* If Case Management was selected, please choose one of the following:  Hourly  Capitated  Outside Referral  CM Authorized Contact: Click to enter text. Phone #: Click to enter text. CM Billing Contact: Click to enter text.  CM Billing Contact Address: Click to enter text. | | | | | | | | | | | | | | | | | | | | | |
| **SmartStarts** | | | | | | | | | | | | | | | | | | | | | |
| **Program Effective Date** | | | **# of Employees** | | | **Rate** | | | | **Provision Effective Date** | | | | | **Penalty / Incentive Yes/No** | | | | | **Type** | |
| Click arrow to enter date. | | | Click here to enter text. | | | Enter rate. | | | | Click arrow to enter date. | | | | | Penalty Yes No | | | | | Health Plan  Other Click to enter. | |
| Incentive Yes No | | | | |
| **Describe Penalty/Incentive:** Click here to enter text. | | | | | | | | | | | | | | | | | | | | | |
| **Nurse Advice Line** | | | | | | | | | | | | | | | | | | | | | |
| **Program Effective Date** | | | | | | | **# of Employees** | | | | | | | | | | | **Rate** | | | |
| Click arrow to enter date. | | | | | | | Click here to enter text. | | | | | | | | | | | Enter rate. | | | |
| **Personal Care Management** | | | | | | | | | | | | | | | | | | | | | |  |  |
| **Program Effective Date** | | **Penalty / Incentive Yes/No** | | | | | | | | | **Applies To** | | | | | **Type** | | | | | |
| Click arrow to enter date. | | Penalty  Yes  No | | | | | | | | | Member  Dependent(s)  or Both | | | | | Health Plan Monetary Reward  Gift Card Flex Spending Acct.  Vacation | | | | | |
| Incentive  Yes  No | | | | | | | | |
| **Describe Penalty/Incentive:** Click here to enter text. | | | | | | | | | | | | | | | | | | | | | |

**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: Click to enter text. Effective Date of Program: Click arrow to select date. Termination Date of Program: Click arrow to select date.

Program Contact: Click to enter text. Phone #: Click to enter text.

Locations Eligible: Click to enter text. Program Cost: Click to enter text.

General Description of Program: Click to enter text.

**CARE MANAGEMENT PACKAGE OPTIONS (This is only available to approved payers.)**

Selection Options: (Check all that apply.)

|  |  |  |  |
| --- | --- | --- | --- |
| \***MedCost Care Management Package** | **Requested Effective Date** | **# of Employees** | **Rate** |
| **Program Components Include:** |  |  |  |
| Inpatient Review |  |  |  |
| Catastrophic Case Management |  |  |  |
| Personal Care Management | Click arrow to enter date. | Enter # of ees. | Enter rate. |
|  |  |  |  |
| **Buy-Up Options:** |  |  |  |
| Outpatient Review – Diagnostic |  |  |  |
| Outpatient Review – Comprehensive |  |  |  |
| SmartStarts Maternity Management –   High Risk |  |  |  |
| SmartStarts Maternity Management –   Comprehensive |  |  |  |
|  |  |  |  |
| **Optional Add-On Program:** |  |  |  |
| Nurse Advice Line | Click arrow to enter date. | Enter # of ees. | Enter rate. |

**\*Note:** There are specific business requirements for implementation of Care Management. A MedCost   
 representative will contact you to begin the implementation process.

**HEALTH MANAGEMENT SUPPLIES**

On-line PPO directories can be accessed at [www.medcost.com](http://www.medcost.com). Flyers and posters are provided at 120% of the employer’s headcount (at no charge). Supplies exceeding this amount will be subject to a charge.

|  |  |  |  |
| --- | --- | --- | --- |
| **Item** | **Quantity** | **Item** | **Quantity** |
| Personal Care Management Flyer |  | Nurse Advice Line Flyer |  |
| Personal Care Management Poster |  | Nurse Advice Line Poster |  |
| Outpatient Review Flyer |  | SmartStarts Maternity Management Flyer |  |
| Inpatient Review Flyer |  | SmartStarts Maternity Management Poster |  |

Ship supplies to:

Contact Name: Click to enter text. Company: Click to enter text.

Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

Email: Click to enter text.

**HEALTH MANAGEMENT ACTIVITY REPORTS**

Contact Name: Click to enter text. Company Name: Click to enter text.

Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

Email: Click to enter text.

**(If additional contact should receive Activity Reports, please indicate below.)**

Contact Name: Click to enter text. Company Name: Click to enter text.

Address: Click to enter text. City: Click to enter text. St: Click to enter text. Zip: Click to enter text.

Email: Click to enter text.