



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: q Addition (New Business) q 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:

Type of Coverage

Self-Insured Fully-Insured Other _____

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 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: _____ Billing Contact Phone #: _____

Billing Contact Fax #: _____ Billing Email: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

REINSURANCE CARRIER INFORMATION

Reinsurance Carrier: _____ Reinsurance Year: _____

Contact Name: _____ Phone #: _____

Street Address: _____ City: _____ State: _____ Zip: _____

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: _____ Email: _____

Contact Name: _____ Email: _____

Contact Name: _____ Email: _____

Contact Name: _____ Email: _____

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: _____ NC - # of employees: _____ SC - # of employees: _____

Other State - # of employees: _____ PEPM Rate: _____

Q 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 steering, 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: _____

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

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: \$_____ 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).

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: _____ 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. 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
				Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe Penalty:				

Outpatient Review

Program Effective Date	# of Employees	Rate	Provision Effective Date	Penalty / Incentive Yes/No
				Penalty <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> Comprehensive List (O3)	<input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No Incentive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Member <input type="checkbox"/> Dependent(s) <input type="checkbox"/> or Both	<input type="checkbox"/> Health Plan <input type="checkbox"/> Gift Card <input type="checkbox"/> Vacation <input type="checkbox"/> Monetary Reward <input type="checkbox"/> Flex Spending Acct.

Describe Penalty/Incentive:

** If Case Management was selected, please choose one of the following: Hourly Capitated Outside Referral

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 <input type="checkbox"/> Yes <input type="checkbox"/> No Incentive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Health Plan <input type="checkbox"/> Other _____

Describe Penalty/Incentive:

Nurse Advice Line

Program Effective Date	# of Employees	Rate

Personal Care Management

Program Effective Date	Penalty / Incentive Yes/No	Applies To	Type	
	Penalty <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Member <input type="checkbox"/> Dependent(s) <input type="checkbox"/> or Both	<input type="checkbox"/> Health Plan <input type="checkbox"/> Gift Card <input type="checkbox"/> Vacation	<input type="checkbox"/> Monetary Reward <input type="checkbox"/> Flex Spending Acct.
	Incentive <input type="checkbox"/> Yes <input type="checkbox"/> No			
Describe Penalty/Incentive:				

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: _____

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

Selection Options: (Check all that apply.)

<input type="checkbox"/> *MedCost Care Management Package	Requested Effective Date	# of Employees	Rate
Program Components Include: Inpatient Review Catastrophic Case Management Personal Care Management	_____	_____	_____
Buy-Up Options: <input type="checkbox"/> Outpatient Review – Diagnostic <input type="checkbox"/> Outpatient Review – Comprehensive <input type="checkbox"/> SmartStarts Maternity Management – High Risk <input type="checkbox"/> SmartStarts Maternity Management – Comprehensive			
Optional Add-On Program: <input type="checkbox"/> Nurse Advice Line	_____	_____	_____

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

Online PPO directories can be accessed at 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: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

HEALTH MANAGEMENT ACTIVITY REPORTS

Contact Name: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

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

Contact Name: _____

Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____