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: _____

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: _____

❑ 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.

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 <u>NOT</u> using MedCost Health Management, please do <u>NOT</u> 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 ❑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:

** 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 ❑Yes ❑No Incentive ❑Yes ❑No	❑Health Plan ❑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 ❑Yes ❑No Incentive ❑Yes ❑No	❑Member ❑Dependent(s) ❑or Both	❑Health Plan ❑Monetary Reward ❑Gift Card ❑Flex Spending Acct. ❑Vacation
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.)

❑ *MedCost Care Management Package	Requested Effective Date	# of Employees	Rate
Program Components Include: Inpatient Review Catastrophic Case Management Personal Care Management	_____	_____	_____
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	_____	_____	_____

***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

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: _____