

# Information Required for a Proposal

## Managed Care Reinsurance



PRESIDIO

CLIENT SPECIFIC INFORMATION

Name of Reinsured: \_\_\_\_\_

Principal Address: \_\_\_\_\_

Owned/Affiliated Hospitals: \_\_\_\_\_

TERTIARY NETWORK SERVICES

Service	DRG	Name of Facility	Contract Basis		
Transplants:	302/480/103/481		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Trauma:	2/485/486		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
NICU:	385-390		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Open Heart:	75/104-108/110		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Tracheotomies:	483		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges
Burns:	941-949		<input type="checkbox"/> Per Diem	<input type="checkbox"/> DRG	<input type="checkbox"/> Charges

NON-TERTIARY NETWORK SERVICES:

Provide a summary of all contracted facilities and contracted rates.

HISTORICAL COST/UTILIZATION

Average Per Diem	Current Yr ( <i>Projected</i> )	1 <sup>st</sup> Prior Year	2 <sup>nd</sup> Prior Year
Commercial:			
Medicare:			
Medicaid:			

Days Per Thousand	Current Yr ( <i>Projected</i> )	1 <sup>st</sup> Prior Year	2 <sup>nd</sup> Prior Year
Commercial:			
Medicare:			
Medicaid:			

ENROLLMENT

Enrollment	Current Yr ( <i>Projected</i> )	1 <sup>st</sup> Prior Year	2 <sup>nd</sup> Prior Year
Commercial:			
Medicare:			
Medicaid:			

*Please attach monthly breakouts.*

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**MEDICAL MANAGMENT**

Describe mechanism that identifies a Covered Person who requires case management.

Describe the measures used to prevent inpatient hospitalization.

Describe the criteria for providing case management services to members.

Please provide the following contact information:

	Contact Name	Phone Number
Director of Medical Management:		
Utilization Review:		
Case Management:		
Transplant Network Vendor:		
Disease Management Vendor:		
Subrogation Vendor:		

**EXCESS CLAIM EXPERIENCE:**

My member classification, provide claim information in the following format for prior 3 years. *(Identify each period.)*

Member Name	Diagnosis or ICD-9	Primary Hospital	In/Out of Network	Dates of Service	Total Charges	Total Paid

**REQUESTED COVERAGE**

Hospital Inpatient Services:  Yes  No      Hospital Outpatient Services:  Yes  No  
 Physician Services:  Yes  No      Conversion Coverage:  Yes  No  
 Insolvency Coverage:  Yes  No      If Yes, Limits required: \$ \_\_\_\_\_

Effective Date: \_\_\_\_\_

Specific Deductible: \_\_\_\_\_

Coinurance Percentage: \_\_\_\_\_ %

# **Information Required for a Proposal**

## **Managed Care Reinsurance**



### ADDITIONAL INFORMATION

Please disclose any material changes to the risk in the most recent 12 months that the Underwriter should note. eg. Changes to Policy benefits, networks utilized, changes in contracting information, etc.

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### DOCUMENTS TO ATTACH WITH THIS FORM:

Hospital Contracting Arrangements  
Covered Benefit Plan  
Last annual NAIC Financial Statement and most recent quarterly filing

Broker of record:  Yes  No If Yes, number of years as BOR: \_\_\_\_\_

Date Quotation Due: \_\_\_\_\_ Presentation Date: \_\_\_\_\_

### SIGNATURE

The proposal will be based upon information transmitted with this form. The undersigned warrants that he or she has made a diligent effort to verify this information; and that, to the best of his or her knowledge and belief, this information accurately represents the facts, and no requested information has been omitted or altered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### CONFIDENTIALITY

This document and any attachments are confidential and also may be privileged. If you are not the named recipient, or have otherwise received this document in error, please notify the sender immediately, delete the document, and do not disclose its attachments to any other person, use them for any purpose, or store or copy them in any medium. Thank you for your assistance.