

# Information Required for a Proposal

## Hospital Capitation Excess Loss



PRESIDIO

CLIENT SPECIFIC INFORMATION

Name of Hospital: \_\_\_\_\_

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

Affiliated Hospitals: \_\_\_\_\_

Cost to Charge Ratio: \_\_\_\_\_ HCFA Provider #: \_\_\_\_\_

Average Cost Per Day: \_\_\_\_\_ Self-Funded employee benefits:  Yes  No  
*(Total inpatient expenses divided by total inpatient days)*

ENROLLMENT

Please provide monthly breakouts and also the most current Financial Responsibility Matrix for each Managed Care Organization.

Managed Care Organization	Commercial	Medicare	Medicaid

TERTIARY NETWORK SERVICES

Identify medical services for which the Hospital is financially responsible but must refer to other facilities. Please name these facilities and provide their contracted rates.

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.



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### 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:			

### MEDICAL MANAGMENT

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

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Describe the measures used to prevent inpatient hospitalization.

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Describe the criteria for providing case management services to members.

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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:

By 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



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### REQUESTED COVERAGE

Hospital Inpatient Services:  Yes  No      Hospital Outpatient Services:  Yes  No  
Physician Services:  Yes  No

Effective Date: \_\_\_\_\_ Specific Deductible: \_\_\_\_\_

Coinsurance Percentage: \_\_\_\_\_ %

### 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  
Copies of the Financial Responsibility Matrices for all Managed Care Organizations

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

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