Information Required for a Proposal

Neonatal Risk

CLIENT SPECIFIC INFORMATION

Health Plan Name/Employer: ______________________

Primary Contact Name: ______________________

Address: ______________________ Phone: __________

HISTORICAL COST/UTILIZATION:

Category	CURRENT	1st Prior Year	2nd Prior Year
Live Births:			
NICU Inpatient Days/1000:			
Average NICU Cost Per Day:			

DEMOGRAPHICS:

For the prior three consecutive 12-month periods, by month, provide for each Covered Person:

- Name/Member ID#
- Age
- Gender
- Zip Code

PROVIDER CONTRACTING

For DRGs 385-390 or corresponding DRG's utilizing the APR-DRG Grouper, please identify:

Name of Referral Facility	Percentage of Total NICU Costs	Contract Basis		
		☐ Per Diem	☐ DRG	☐ Charges
		☐ Per Diem	☐ DRG	☐ Charges
		☐ Per Diem	☐ DRG	☐ Charges
		☐ Per Diem	☐ DRG	☐ Charges
		☐ Per Diem	☐ DRG	☐ Charges
		☐ Per Diem	☐ DRG	☐ Charges

(Please attach a copy of each Provider contract reference above.)

Presidio Excess Insurance Services, Inc.
199 Fremont Street, 11th Floor
San Francisco, California 94105
415.354.1551 phone 415.354.1590 fax underwriting@pxis.com

Information Required for a Proposal

Neonatal Risk

CLAIM EXPERIENCE

1. Identify ALL newborns for each of the prior three 12-month periods by Member ID, Date of Birth, Relationship to member, Class, Gender and ALL members with expenses for treatment of ICD9 codes 628.00 through 677.99
2. Extract ALL claim records for each Covered Person identified in number one
3. The records are to include the items:

   Medical Costs
   Hospital costs
   Pharmacy costs
   Laboratory costs
   Professional costs
   DME costs
   Home Health costs
   Ancillary costs

   Standardized Code Information

Provider Type	(Hospital, SNF, PCP, Specialist)
Provider Name	(Provider ID Number)
Code Description of Service	(CPT, HCPCS, Revenue Code, Modifiers – Uniform Codes
Site of Service HCFA Standard	(Office, Lab, Outpatient or Inpatient Hospital)
Referral Provider	(Authorization for Out-of-Area or Non-Contracted Provider)
Dates of Service	(From and To Dates)
Quantity of Service	(# of Identically Coded Services or Length of Stay)
Charge for Service	(Billed Amount)
Paid/Value of Service	(Note: use “Value” for Capitated Services)
Paid Date Transaction Date	(Process Date)
Diagnosis	(UB92 Revenue Codes, CPT/HCPCS Procedures, ICD9 Diagnostic (Primary and Secondary), Home Grown)
DRG	(If contract requires or “Paid” based on DRG)

MEDICAL MANAGMENT

Describe your medical management process as it pertains to the UM/CM provided for high-risk neonates throughout the continuum of care:

Describe the benefit plan design as it relates to the critical and ongoing care provided to the high-risk neonate throughout the continuum of care:

Describe any special products and services specifically designed for the medical management of the high-risk neonate:

Describe your medical management services provided for high-risk maternity patients:

____

Presidio Excess Insurance Services, Inc.
199 Fremont Street, 11th Floor
San Francisco, California 94105
415.354.1551 phone 415.354.1590 fax underwriting@pxis.com

Information Required for a Proposal

Neonatal Risk

MEDICAL MANAGEMENT CONTINUED

Does your organization provide benefits for members diagnosed with pre-term labor or multiple gestation that may require the following? *(Check all that apply)*

☐ labor management programs ☐ uterine activity monitoring
☐ fetal fibronectin assay testing ☐ oral and continuous subcutaneous tocolytic infusion
☐ daily telephonic perinatal nursing assessment and surveillance

Does your organization provide benefits for members diagnosed with gestational or pregestational diabetes mellitus that may require the following? *(Check all that apply)*

☐ intensive outpatient monitoring and assessment of glycemic control specific to pregnancy
☐ dietary and exercise education, etc.

Does your organization provide benefits for members diagnosed with mild pregnancy induced hypertension or mild pre-eclampsia that may require frequent or daily monitoring and assessment of blood pressure proteinuria, weight and non-stress tests?

☐ Yes ☐ No.

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.

Presidio Excess Insurance Services, Inc.
199 Fremont Street, 11th Floor
San Francisco, California 94105
415.354.1551 phone 415.354.1590 fax underwriting@pxis.com