

Information Required for a Proposal

Physician Capitation Excess Loss



PRESIDIO

CLIENT SPECIFIC INFORMATION

Name of Provider: _____

Principal Address: _____

Provider's ability to submit claims electronically: Yes No
(Please note that the above is a requirement to issuing terms.)

ENROLLMENT

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

Managed Care Organization	Commercial	Medicare	Medicaid

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:		

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DOCUMENTS TO ATTACH WITH THIS FORM:

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

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.