OhioHealth Group

CUSTOMER ORIENTATION CHECKLIST

We are pleased to welcome a new OhioHealth Group customer! Information about our customers is an important element in our efforts to provide you with quality customer service and communication. Please complete this form and fax to OhioHealth Group at (614) 566-0484. If you have questions regarding the completion of this form, contact an OhioHealth Group Account Executive at (614) 566-0123. We look forward to working with you!

❑ NEW GROUP ❑ Existing Group w/New TPA Existing Group#_______________

EMPLOYER GROUP INFORMATION **Fully Insured ❑ Self-Insured ❑**

Group's Exact Legal Name ____

Group Effective Date__________________ **Group Renewal Date**________________ **Group Type**____________________

Name As it Should or Does Appear on ID Card ______________________________________

Group Number __________________ **E-mail:** ______________________________ **County** ______________________

Address ____ **City** ______________________ **State/Zip** _________________

Other Locations/Divisions (name and addresses) ____

____

Key Contact ____ **Title** ____

Phone ____ **Fax** ____

Billing Contact (*if not TPA*)_________________________________ **Title**____

Phone ____ **Fax** ____

Billing Address ____

Total Number of Employees _________ **Number of Employees Enrolled in PPO** __________

Managed Care Services Elected:	**Service Fees:**		
❑ Physician & Hospital Network	$_____________	❑PEPM	❑OTHER_________
❑ Basic Care Management (pre-certification, concurrent review & retrospective review for in-patient admissions).	$_____________	❑PEPM	❑OTHER_________
❑ Case Management (follows patient through full episode of illness/treatment)	$_____________	❑PEPM	❑OTHER_________
❑ Claim Repricing	$_____________	❑PEPM	❑OTHER_________
❑ Pharmacy Network Services	$_____________	❑PEPM	❑OTHER_________
❑ ID Cards	$_____________	❑Per Card	❑OTHER_________
❑ Directories	$_____________	❑Per Directory	❑OTHER________
❑ Other______________________________	$_____________		

Tier Type(s) – *please check all that apply*

❑ E Only ❑ E +Spouse ❑ E+Children ❑ E+Child ❑ E+1 ❑ E+2 ❑ E+3 or more ❑Family

Benefit Differential %________(this is the difference between in and out of network coinsurance %)

Directories Needed ❑ Yes ❑ No Quantity ________

❑ HealthReach ❑ Custom ❑ Rx

ID Cards Provided by OhioHealth? ❑ Yes (Enrollment required; including complete name, social security number, coverage choice i.e. single/family)
❑ No (OhioHealth Group logo must appear on card or we will provide stickers at your request. A copy of the ID card is required.)

BROKER/CONSULTANT INFORMATION

Name ____ **Phone** _______________________ **Fax** ______________________

Address ____ **City** ________________________ **State/Zip** _______________

Key Contact ____ **Title** ____

Additional Contact ____ **Title** ____

TPA/CLAIM ADMINISTRATOR INFORMATION

Name ____ **Phone** _____________________ **Fax** _____________________

Address ____ **City** ________________________ **State/Zip** _________________

Key Contact _____________________________________ **Title** _____________________ **Phone** ___________ **Fax** ___________

Claim Contact __________________________________ **Title** ______________________ **Phone** ___________ **Fax** ___________

Claim Address (if different from above) ____

____

Repriced Claims Address (if different from Claims Sent to) ____

____

Claims Sent to: ❑ OhioHealth Group ❑ TPA

Employer Service Fee ___ Billed by OhioHealth Bills Sent to: • TPA • Group

Provider File to TPA ❑ Yes ❑ No If yes, via ❑ Disk ❑ Hard Copy

Provider File Contact _________________________________
Phone ______________________ Fax __________________

Fee Schedule to TPA ❑ Yes ❑ No

Fee Schedule Contact _________________________________
Phone ______________________ Fax ___________________

4% Administrative Fee
Sends Reports? • Yes • No • Paper • Electronic
Auto Remit • Yes • No

CUSTOMER/CLIENT PLAN DESCRIPTION SUMMARY – <u>In-Network</u>

Deductible Single: $________
Deductible Family: $________
Office Visit Co-Pay/Co Insurance: $______

UR PROVIDER

Name ____ **Phone** ______________________ **Fax** ____________________

Address ____ **City** ____________________**State/Zip** __________________

Key Contact ____ **Title** ____

Pre certification Requirement: ❑ **INPATIENT**
❑ **OUTPATIENT SURGERY**
❑ **MENTAL HEALTH/CHEMICAL DEPENDENCY**

Pre certification Phone ___________________________

Note: Please fill out below if OhioHealth Group is UR Provider

PRECERTIFICATION, CONCURRENT AND/OR RETROSPECTIVE REVIEW		
INPATIENT		
	Hospital	Routine [ ] Yes [ ] No
	Maternity	High Risk [ ] Yes [ ] No
	Routine Maternity	Pre certification, concurrent and retrospective review of routine maternity admissions are done only if the patient requires greater than 2 days of hospital stay after a vaginal delivery or greater than 3 days of hospital stay after a Cesarean section; or if the patient is experiencing complications or becomes "high risk" at any point during the pregnancy.
	Extended Stay of Mother	If the mother requires an extended stay that is medically indicated, the infant's stay will be reviewed for medical necessity. Each case will be reviewed individually
	Extended stay of Infant	Unless the mother goes home on the day of delivery, infant admissions will be added from the date of birth rather than the mother's discharge date.
	Skilled Nursing	[ ] Yes [ ] No
	Hospice	[ ] Yes [ ] No
	Rehabilitation	[ ] Yes [ ] No

UR PROVIDER Continued.

OUTPATIENT		
	Surgery (Performed in other than provider's office)	[ ] Yes [ ] No
	Home Care	[ ] Yes [ ] No
	Skilled Nursing	[ ] Yes [ ] No
	Hospice	[ ] Yes [ ] No
	Rehabilitation	[ ] Yes [ ] No
	Home Medical Equipment	[ ] Yes [ ] No
	Chiropractic	[ ] Yes [ ] No
	Mental Health/Chemical Dependency	[ ] Yes [ ] No
CASE MANAGEMENT	[ ] Yes [ ] No	If no, indicate case management company ____ ____ _________
ER/UR HOSPTIAL ADMISSION NOTIFICATION		_____ Hours or ______ Business days
PENALTY FOR NO PRECERTIFICATION		[ ] to employee $ [ ] to provider $
SECOND SURGICAL OPINION	[ ] Mandatory [ ] Voluntary	
NOTIFICATION TO TPA	[ ] At Admission [ ] At Discharge	VIA: Mail [ ] Fax [ ] #(___)_________ Fed Ex [ ] Electronic Tape/Disk [ ]

Pharmacy (Rx) Information

Pharmacy Provider

Name ____ **Phone** _______________________ **Fax** ______________________

Address ____ **City** ________________________ **State/Zip** ______________

Key Contact ____ **Title** ____

Additional Contact ____ **Title** ____

Copays

Retail
Brand $_______________Generic $_______________

Mail Order
Brand $_______________Generic $_______________

Rx Network: [ ] 73 [ ] 136

Tiered Copays -- [ ] yes [ ] no
If yes, preferred brand copay: _________

Mail Order Pharmacy Name: [ ] Scrip Pharmacy [ ] PharmaCare Direct
Rx Only ID cards? [ ] yes [ ] no PPO w/Rx ID cards? [ ] yes [ ] no