



SOLD CASE NOTIFICATION

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 return it to OhioHealth Group as soon as possible. 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 _____ Full PPO Wrap PPO Rx

Please provide the names of any other networks that this group may have:

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:

- Physician & Hospital Network (PPO)
- Basic Care Management (pre-certification, concurrent review & retrospective review for in-patient admissions).
- Case Management (follows patient through full episode of illness/treatment)
- Claim Repricing
- Pharmacy Network Services
- ID Cards
- Directories
- Other _____

Service Fees:

- \$ _____ PEPM OTHER _____
- \$ _____ PEPM OTHER _____
- \$ _____ PEPM OTHER _____
- \$ _____ PEPM OTHER _____
- \$ _____ Per Card OTHER _____
- \$ _____ Per Directory 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

****SEND ELECTRONIC ELIGIBILITY FILES TO: OHGECR@OHIOHEALTHGROUP.COM**

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 Group? 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 _____

Address to mail repriced claims _____

Providers send claims to: OhioHealth Group TPA address _____

Network Access 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

UR PROVIDER		
Name _____	Phone _____	Fax _____
Address _____	City _____	State/Zip _____
Key Contact _____	Title _____	e-Mail _____
Precertification Requirement: <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT SURGERY <input type="checkbox"/> MENTAL HEALTH/CHEMICAL DEPENDENCY		
Precertification 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	Precertification, 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 CONT.

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

Pharmacy (Rx) Information

Pharmacy Provider

Name _____ Phone _____ Fax _____

Address _____ City _____ State/Zip _____

Key Contact _____ Title _____

Additional Contact _____ Title _____

Copays

Retail
Brand \$ _____ Generic \$ _____

Rx Network: 73 136

Mail Order
Brand \$ _____ Generic \$ _____

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

FOR INTERNAL OFFICE USE ONLY

ELIGIBILITY (E-mail electronic files to: OHGECR@ohiohealth.com)

**For Renewal's only: Currently receive a monthly file? _____ (if not, please request a full file)

If New Group: Do we have a full electronic elig. file to load? _____ YES _____ NO
(only needed for RX, repricing, etc., not needed for network access)

Systems: Please provide date Group information was loaded. _____

REPRICING

REGION# _____

Is there run-in?

YES

NO

What date does the run-in end?

Which dates-of-service are involved in the run-in?

Sales Representative _____ Account Executive _____