REQUEST FOR PROPOSAL - HMO

CLIENT SPECIFIC INFORMATION

1. **Name and Primary Address:** _____

2. **Coverage Requested:** ☐ Hospital ☐ Professional ☐ Combined ☐ Conversion ☐ Insolvency

3. **Deductible(s) Requested:** Hospital _____ Professional _____ Combined _____

4. **Coinsurance:** _____

5. **Effective Date:** _____

6. **Membership: Please provide monthly enrollment for the previous 36 months as well as the current membership:**
   Commercial _____ **Medicare** _____ **Medicaid** _____

7. **Tertiary Network: Please list the facilities where the following services will be provided. Please also include the contract terms for each:**

Service	Name of Facility	Contracted	Contract Basis
Transplants		yes / no	
Trauma		yes / no	
NICU/Preemies		yes / no	
Cardiac		yes / no	
Burns		yes / no	

8. **Non Tertiary Network: Please include a summary of all contracted facilities and rates (including outliers).**

9. **Utilization and Cost: Please provide Average Charge per Day as well as Days Per Thousand**

Average Per Diem	Current Year (projected)	Prior Year	2nd Prior Year
Commercial			
Medicare			
Medicaid			

Days Per Thousand	Current Year (projected)	Prior Year	2nd Prior Year
Commercial			
Medicare			
Medicaid			

10. **Claim Experience: Please provide the following claim information for the prior three years, by member, by year, in an excel format: Member Name, Diagnosis, Provider Name, In/Out Network, Dates of Service, Total Charges, Total Paid**

11. **Please provide a copy of the expiring Reinsurance Agreement as well as any requested changes to the coverage.**

12. **Please provide reimbursement basis by covered service. For Example: Inpatient Hospital Services – the lesser of % contracted, % paid, % billed or per diem/average daily maximum; Pharmaceuticals and Injectables – the lesser of % contracted, % paid, % billed or $per member per agreement period maximum.**

13. **Broker of Record:** ☐ Yes ☐ No

14. **Date proposal is due:** _____

REQUEST FOR PROPOSAL – PROVIDER EXCESS OF LOSS

CLIENT SPECIFIC INFORMATION

1. **Name and Primary Address:** _____

2. **Coverage Requested:** ☐ Hospital ☐ Professional ☐ Combined
3. **Deductible(s) Requested:** Hospital _____ Professional _____ Combined _____
4. **Coinsurance:** _____
5. **Effective Date:** _____

6. **Managed Care Organizations:**
Please provide monthly enrollment for the previous 36 months as well as the current membership and Financial Responsibility Matrix for each MCO:

	CURRENT MEMBERSHIP			
Managed Care Organization	**Commercial**	**Medicare**	**Medicaid**	**Matrix Attached**

7. **Tertiary Network: If requesting facility coverage, please list the facilities where the following services will be provided. Please also include the contract terms for each:**

Service	Name of Facility	Contracted	Contract Basis
Transplants		yes / no	
Trauma		yes / no	
NICU/Preemies		yes / no	
Cardiac		yes / no	
Burns		yes / no	

8. **Non Tertiary Network: If requesting facility coverage, please include a summary of all contracted facilities and rates (including outliers).**

9. **Utilization and Cost: If requesting facility coverage, please provide Average Charge per Day as well as Days Per Thousand**

Average Per Diem	Current Year (projected)	Prior Year	2nd Prior Year
Commercial			
Medicare			
Medicaid			

Days Per Thousand	Current Year (projected)	Prior Year	2nd Prior Year
Commercial			
Medicare			
Medicaid			

10. **Claim Experience: Please provide the following claim information for the prior three years, by member, by year, in an excel format: Member Name, Diagnosis, Provider Name, In/Out Network, Dates of Service, Total Charges, Total Paid**

11. **Please provide a copy of the expiring Policy as well as any requested changes to the coverage.**

12. **Please provide reimbursement basis by covered service. For Example: Inpatient Hospital Services – the lesser of % contracted, % paid, % billed or per diem/average daily maximum; Physician Services – the lesser of % contracted, % paid, % billed or % of RBRVS for specific locality/geographic area.**

13. **Broker of Record:** ☐ Yes ☐ No
14. **Date proposal is due:** _____