OhioHealth Group

Send to Jill Dong at OHG

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:	**Service Fees:**		
❑ Physician & Hospital Network (PPO)	$_____________	❑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

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 Reqirement:
- ❑ **INPATIENT**
- ❑ **OUTPATIENT SURGERY**
- ❑ **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)	[ ] 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 $_______________ 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______________________________________