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PPO Network Questionnaire

GENERAL INFORMATION

Network Name			
Street Address	City	State	ZIP Code
Contact Name			
Email Address	Phone Number	Fax Number	

NETWORK INFORMATION

1. Has your network been involved in mergers and/or acquisitions in the past two years? ☐ Yes ☐ No

   If Yes, please explain:

2. Which of the following features do you offer? *Check all that apply.*

   ☐ HMO
   ☐ PPO
   ☐ POS
   ☐ EPO

3. List Network Service Area(s)

4. Enrollment Data
   Current Year: _____ Prior Year: _____

5. Percentage of eligible individuals currently utilizing network facilities: _____

6. Does your network provide in-house repricing? ☐ Yes ☐ No

If Yes, please provide the information requested in sections 7, 8 and 9. If No, please skip these sections and continue to section 10.

FOR NETWORKS PROVIDING IN-HOUSE REPRICING ONLY

7. Provide claimant-by-claimant listings of all in-network claims where billed charges are more than $25,000 before and after repricing (billed and repriced) for the latest 12-month period. Identify the network hospital for each claimant, length of stay, hospital state, ZIP code and primary diagnosis code. The listing should include all claims by claimant and exclude secondary payor and ineligible claims.

Example:

CLAIMANT	TOTAL BILLED	TOTAL ALLOWED	EMPLOYEE STATE	EMPLOYEE ZIP CODE	HOSPITAL NAME	HOSPITAL STATE	HOSPITAL ZIP CODE	LENGTH OF STAY	PRIMARY ICD CODE	PLAN
000001	$47,122.58	$31,961.01	NJ	080	ABC	NJ	080	6	P220	HMO
000004	$42,378.43	$21,901.64	NY	212	DEF	NY	212	5	C155	HMO
000008	$49,543.16	$32,425.01	NY	212	GHI	NY	212	12	J9620	PPO

If your provider contracts differ for your EPO product and your PPO product, please provide this information separately.

8. For the same 12-month period, provide total (all claims down to first-dollar) in-network billed claims and total allowed claims by the first three digits of the employee ZIP codes.

Example:

STATE	ZIP CODE	# OF CLAIMANTS	TOTAL BILLED	TOTAL ALLOWED
NJ	080	44,570	$70,200,000	$50,200,000
NY	212	16,566	$40,300,000	$20,400,000

9. For the same 12-month period, provide membership counts by ZIP code.

Example:

MEMBER ZIP CODE	MEMBER STATE	ENROLLMENT MONTH	ENROLLMENT YEAR	MEMBERS COUNT
080	NJ	1	2019	1627
212	NY	1	2019	2024

If this information is not available, please provide the data for sections 7 and 8. If you are unable to provide the data in sections 7-9, please provide the data requested for sections 10 and 11.

10. List all contracted hospitals. Include hospital name, city, state, ZIP code, tax identification number and the terms of the contract, including any outlier (Stop Loss) provisions, as well as each hospital's reimbursement type and discount:
- Per diem by type (medical, surgical, ICU, NICU, psych)
- DRG base rates
- Flat percentage discounts
- Percentage of Medicare

Example:

HOSPITAL NAME	CITY, STATE ZIP CODE	TAX ID NUMBER	CONTRACT TERMS	OUTLIER (STOP LOSS) PROVISION	REIMBURSEMENT TYPE	REIMBURSEMENT TERMS
General Hospital	Voorhees, NJ 08043	XXX-XXX-XXX	24/12	Claims in excess of $150,000 paid at 80% of charges	Per diem	Medical = $1,500 Surgical = $1,750 ICU = $2,500

If your contracts differ by product, please provide contract information for each product.

11. Provide the average savings by metropolitan service area for each of the following categories: Inpatient, Outpatient, Physician and Pharmacy.

Example:

MSA	INPATIENT	OUTPATIENT	PHYSICIAN	PHARMACY	TOTAL
Voorhees	50%	48%	40%	55%	45%

IMPORTANT NOTE:
Sections 7 through 11 must be submitted in a Microsoft Excel format. Return this form and the completed Excel file to **Marlton Risk Management, LLC.**

_____ _____ _____

Signature Title Date