Ullico
SOLUTIONS FOR THE UNION WORKPLACE

CLAIMS ADMINISTRATOR QUESTIONNAIRE

PAGE 1

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 800-328-5837 • Fax: 1-202-682-6920

The following form will be used for informational purposes by The Union Labor Life Insurance Company only. This form will be used to determine if you as a prospective claims payor, have the capabilities to efficiently process claims for the group mentioned below and the ability to interact with the systems in place at The Union Labor Life Insurance Company. All questions must be answered completely in order for this questionnaire to be accepted and responses will be considered confidential.

Please include information about the individual(s) primarily responsible for responding to this questionnaire. You may attach a business card.

Completed By:_____ Title: _____

Date Completed:_____ Telephone Number: _____

Group name of the client for whom you would like to be designated as a primary claims payor:

_____

SECTION I. GENERAL INFORMATION

Claims Administrator's Legal Name & Tax ID #	
Street Address	
City, State, Zip	
Telephone	Phone: Fax:
Email/ Website address	

SECTION II. OWNERSHIP AND ORGANIZATION

1. Legal Form of Entity:	❑ Corporation ❑ Partnership ❑ Fund ❑ Other:
2. Location of satellite offices (if any) and telephone numbers:_____	
3. Is your firm owned by or affiliated with any other organization(s) involved, directly or indirectly, in any area or aspect of insurance or reinsurance?	
❑ Yes If yes, please provide name, address, relationship and nature of business._____	
❑ No	
4. How long has your organization been operating as a claims administrator?	

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5. Have you operated under any other name? ❑ Yes ❑ No

If yes, please provide other name(s), legal form of business, and location(s)._____

6. Are there any pending law suits or legal actions that have been brought against your firm, any affiliated firm, or any of the principals during the past three (3) years? ❑ Yes ❑ No If yes, please provide an attachment with details._____

7. Key Administrators:

A. For a Corporation or Fund, list all members of the Board of Directors._____

B. For a partnership, list all partners._____

C. Key Contact Person For: Company/Corp. Relations

Name	Title	Length of Service	Phone	Email

Key Contact Person For: Claims

Key Contact For: Plan Administration

Key Contact For: Accounting

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SECTION III. INSURANCE ADMINISTRATION PROFILE

1. List number of groups and percentage of client base under each type.

	Number of client Cases		Percentage of Client Base	
A. Taft-Hartley				
B. Employer				
C. All Other				

2. Please provide the following regarding your current book of business:

	Current Book of Business		Additions in Last 24 Months	Lost Business in Last 24 Months
A. Total Clients				
B. Total Employee Lives				
C. Total Participants				
D. Paid Claims ($$ amount)			N/A	N/A

SECTION IV. CLAIMS ADMINISTRATION

1. How many full-time trained claims examiners excluding the supervisor, are employed?_____

2. Average production of claims per day _____ per month _____ per year _____

3. Total claims paid on-site _____ satellite locations _____ total claims per day _____

4. Are all claims examiners, supervisors, draft typists and claims clerks bonded? ❑ Yes ❑ No

If yes:	Insuring Company		
	Policy Number		Term
	Limits		

5. If the insuring company has changed within the past 2 years, provide the same information for the prior carrier and give the reason for the change:

Prior Insuring Company	
Policy Number	Term
Limits	
Reason for Change	

6. Are all claims examiners who are utilized as temporary processors through placement agencies bonded? ❑ Yes ❑ No

7. How many (average) years of experience does each permanent staff member have?

Claims Examiners _____ Claims Managers _____

8. Describe claims training program i.e. length of training, which system applications are reviewed, does this involve customer service training as well? *(attach additional sheet if necessary*).

9. Describe in detail your fraud program to include check stock security (*attach additional sheet if necessary*).

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10. Do you have a dedicated customer service unit/call center? ❑ Yes ❑ No	
If yes:	What is your standard for average speed to answer?
	What are your standards on abandoned calls?
	What are your hours of operation?

11. Please describe your claims quality standards?

Procedural _____ %

Financial _____ %

12. What are your claims quality results for the past two years?

13. Please describe your quality audit program?

14. If claims processing is automated, briefly describe hardware and software utilized, including name of software package and key functionality (auto adjudication, scanning, EDI).

15. Do you use a clearinghouse to receive and transmit electronic claims and transactions? ❑ Yes ❑ No

If yes, what is the name of the clearinghouse and how do you receive the claims? (Web, FTP, etc.)

16. What claims processing procedure do you use?

❑ Entirely Manual;

❑ Partially Automated (manual claim adjudication with system generated claims drafts and statistical data)

❑ Entirely Automated

If you are not automated, do you have plans for upgrades in the near future? Please state plans and dates of implementation.

17. What claims processing manual does your firm use or subscribe to?

18. Which medical services codes do you capture in your adjudication system (i.e., CPT, ICD9, CM, DRG, ADA, HCPCS, etc.)?

19. Are these codes available for reporting and electronic distribution? ❑ Yes ❑ No

20. If not, when do you expect to have the capabilities in place? (_____Date)

21. Is your firm capable of sending a full electronic claim feed to our company each month? ❑ Yes ❑ No

After each claim run? ❑ Yes ❑ No

If not, when do you expect to have the capabilities in place? (_____Date)

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22. Are records maintained which would allow retrieval of the following information:		
Date Medical Expense was incurred by Claimant	❑ Yes	❑ No
Date Medical Expense was Paid?	❑ Yes	❑ No
Amount Paid, Check No., Benefit Type & Diagnostic Code by Claimant	❑ Yes	❑ No
PPO vs. Non-PPO Utilization & Discounts	❑ Yes	❑ No
Enrollment, Eligibility & Employment Dates	❑ Yes	❑ No
Liability Determination (i.e. COB; Workers' Compensation)	❑ Yes	❑ No

23. If more than one of the above capabilities is not currently in place, do you plan on redesigning your system to accommodate the necessary records? ❑ Yes ❑ No by, (_____DATE)

24. How are paid claims stored electronically _____

Physically_____

For how long?_____

25. For recording purpose, do you use the incurred date when there are multiple service dates on a claim draft/check? ❑ Yes ❑ No

26. Does the Explanation of Benefits form that is generated by your system indicate PPO discounts?
❑ Yes ❑ No If no, explain further. _____

Please attach a sample of your Explanation of Benefits form.

27. Can your organization warrant and represent that it has administrative, technical and physical safeguards to:

Protect against anticipated threats or hazards to the security or integrity of customer records and information obtained by financial institutions? ❑ Yes ❑ No

Protect against unauthorized access to or use of such records or information which could result in substantial harm or inconvenience to any customer? ❑ Yes ❑ No

Insure the security and confidentiality of customer records and information? ❑ Yes ❑ No

28. Describe your security system for customer records and information. _____

_____

29. Do you have a disaster recovery procedure in place? ❑ Yes ❑ No

If no, explain further _____

_____

Please attach a copy of your disaster recovery procedures.

30. Are you NCQA Accredited? ❑ Yes ❑ No

31. Are you accredited by any other organizations (JACHO, URAC, etc)? If so, please list organizations._____

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32. Can the organization warrant and represent that it can conduct transactions that meet all the standards for electronic transactions as set forth in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant to that Act?
❑ Yes ❑ No

If yes, which of the transactions do you anticipate conducting with The Union Labor Life Insurance Company?

_____

If no, have you obtained an extension and when do you expect to become compliant? (_____DATE)

SECTION V. COST MANAGEMENT

1. What R&C fee schedule and percentile do you use?
2. Do you have an existing cost management program or do you currently administer a plan with a cost management program? ❑ Yes ❑ No
3. What UR firm do you use (name, address and contact person)? _____
4. Describe your program for large case management, including the consultants or vendors used for complex claims, transplants, hospital audits and negotiating discounts, etc. _____
5. What criteria is used to determine when a Hospital Bill Audit is performed?
6. Please provide a list of your PPO relationships?
7. What is your process relating to securing discounts on Non-PPO claims?
8. Do you have a specific vendor that is used for negotiating cost for dialysis treatment and high cost prescription drugs? ❑ Yes ❑ No
   If Yes, Who?
9. Describe your subrogation procedures and the measures used to ensure recovery.

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SECTION VI. ADDITIONAL INFORMATION REQUIRED

Please attach the following required items via hardcopy or through email before submitting the completed questionnaire:
❑ Sample of claims and management reports and EOBs for clients
❑ Copy of administrator licenses and certificates of authority for all states in which you do business
❑ Copy of your most recent audited financial reports
❑ Credit Report
❑ Copy of Fiduciary and/or Errors and Omissions coverage

I HEREBY CERTIFY TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT THE ABOVE INFORMATION IS CORRECT. I ALSO UNDERSTAND THAT AS A MATTER OF PROCEDURE, A ROUTINE INQUIRY MAY BE MADE BY THE COMPANY OF ANY OR ALL OF THE INDIVIDUALS AND FIRMS NOTED HEREIN AS REFERENCES IN THIS QUESTIONNAIRE. ANY SUBSTANTIVE CHANGE IN THE INFORMATION PROVIDED IN THIS APPLICATION SHALL BE COMMUNICATED IN WRITING WITHIN 30 DAYS.

Date:	Signed:
	Title:
Mail To:	Please forward an electronic copy of the completed questionnaire within 10 days of the client's decision to award Union Labor Life with the business to Kathy Fullen, Installation Coordinator at kfullen@ullico.com. This signature page should be signed and sent along with all hardcopy attachments to: The Union Labor Life Insurance Company Group Installations Department, 8403 Colesville Road, 13th Floor Silver Spring, MD 20910 If you have any questions, please contact Kathy Fullen at 202-682-6905.

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