



TPA QUESTIONNAIRE

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Entity, Location, Ownership, Affiliation:

Name: _____

Address: _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____ Website _____

T.I.N. # _____ Type of Business: Corporation Partnership Sole Proprietor

List of Officers: *(Attach additional list if necessary. Submit resumes of Officers, Directors and Owners)*

President _____ Secretary _____

Vice President _____ Treasurer _____

Please list other companies with whom you have financial interest (i.e., insurance companies, PPO's, HMO's, MGU's, Brokerage operations, etc.)

In the last 5 years has your business entity ever been involved in a merger? No Yes
If yes, please describe:

In the last 5 years has your business entity ever had a change in ownership? No Yes
If yes, please describe:

Has your business entity had a change of name, used a d.b.a. or is it operating under an assumed name?
No Yes ; if yes, previous name was: _____

Branch Offices:

NAME ADDRESS PHONE



Systems Administration And Claims (Hardware & Software)

Administration

Claims

- I. Is system on-line or manual?
- II. Name of Software system
- III. Who developed?
- IV. Year of development
- V. Is software lease, timeshared, or owned?
- VI. If owned, year purchased
- VII. Name of hardware;
- VIII. Is hardware leased, timeshared or owned?

- IX. Have you ever changed/upgraded systems, within 12mo? No Yes if Yes, please describe:

Administrative Services (Financial Eligibility & Premium Accounting)

Staff: Total number of employees in department
 Name/Job Title of Key Personnel & Managers Yrs. Experience Yrs. w/current Employer

If necessary, list additional names on a separate page & attach. Please attach resumes.

- 1. May clients have system access in their offices? No Yes ; if yes, which administrative functions can the client perform? _____

- 2. Can you provide census and premium data electronically? No Yes

- 3. System(s) Security & Audit Procedures:
 - i. Describe Security for master file: (ie, who can enter new groups, changes).

 - ii. Describe security for client funds.

 - iii. Describe record retention program for enrollment cards, billing files, etc.

 - iv. Describe back-up system in the event that the computer master file is destroyed.

- 1. Does your system calculate individual or group premium? No Yes ; Or, are they manually calculated and entered in the master file? No Yes

Administrative Services (Financial Eligibility & Premium Accounting) Continued

- 2. Describe procedures for adding, deleting and changing Plan Participants and their benefits.

- 3. Do you perform bank account reconciliations on Client Accounts? No Yes
- 4. How often do you generate premium billings? _____ On what Days? _____
- 5. When are premium reminder notices sent? _____
- 6. When are lapse notices sent? _____
- 7. On what dates(s) are premium payments run for insured & reinsurers?

Claims

Staff: Total number of employees in: **Adjudication** _____ **Support** _____ **Managers** _____
Name/Job Title of Key Personnel & Managers Years Experience Yrs. w/current Employer

If necessary, list additional names on a separate page & attach. Please attach resumes.

- 1. How many terminals are in use? _____
- 2. Is eligibility determined on-line? No Yes
- 3. How long is claim history maintained on-line? _____
- 4. Has the department been audited by a third party for accuracy/security? No Yes ; if yes, give date and name of audit firm: _____

Type of audit:	CPA/5500	CPA/Performance	Carrier/MGU	Independent Claims Audit
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- 5. Can you provide claim data electronically? No Yes
- 6. Claims are largely (ie: +75%)
a) Processed Manually On-Line
b) Filed By Family Batch
- 7. What does a claim represent? (check one) Line item Check E.O.B.
Other?

Based on the above definition:

- a) Average number of claims processed per processor per hour is _____
- 8. What is your payment accuracy objective?
 - a) Statistical: Number of claims paid _____
 - b) Financial: Dollar amount paid without error _____

Claims (continued)

9. Describe the payment authority limitation for the claims staff and describe the criteria for internal audits.

10. What is your payment accuracy performance during the last twelve months?

11. What is your turnaround objective? _____

12. What is your average turnaround time over the last twelve Months? _____

13. Surgical R&C is based upon: HIAA Internal MDR Med-Index Other ;
If other, please describe:

Surgical: _____

Medical: _____

Dental: _____

14. Is your R&C database on-line? No Yes How often is R&C data updated? _____

15. Are ICD-9 codes captured? No Yes

16. Are CPT codes captured? No Yes

17. For what period of time are hard copy claims files retained?

18. Are separate bank accounts maintained for each client? No Yes

a) What is included in each account?

b) Who has disbursement authority? _____

c) Is there a trust established for Funded Plan? No Yes ; Describe a "typical" clients funds transactions through your office

19. Do you subcontract any data processing activities? No Yes ; if yes, please specify

Do you utilize off site or home claim processors? No Yes ; if yes, please specify

20. Describe your procedures for professional Medical & Dental claims review: _

21. Describe your procedures for auditing and/or negotiating provider bills:

Claims (continued)

22. Describe your procedures for using Large Case Management (LCM):

23. Describe the Managed Care Procedures you are using: _____

Carriers (See Marketing Questionnaire for greater detail)

1. Please list the stop-loss carriers with which you have business:

Carrier Name	# of Cases	# of Lives	Annual Premium
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2. Has any carrier terminated their relationship with you in the last 5 years? No Yes if yes, who and why:

Compliance/ Legal/ License

1. Describe any previous or pending material lawsuits in the last 10 years;

2. Have any of the principals in your firm or any of your employees (former or current), ever been indicted or convicted of mishandling/misappropriating any insurance company or client funds?

No Yes Give details;

3. Describe your current procedures for handling client or insured complaints and State Insurance Department complaints.

4. Has the TPA or its principals ever been adjudged bankrupt? No Yes Explain:

5. Have you been involved in an audit by the Department of Labor? No Yes ;_if yes, give Details: _____

Compliance/ Legal/ License - Continued

6. Does your operating jurisdiction(s) require licensing? Are you licensed as a: States

- Third Party Administrator
- Managing General Agent
- Agency
- Broker
- Agent

Please provide a copy of current license(s) listed above.

7. How are you kept informed of changing legal requirements within your market area?

How do you inform your clients of these changes? _____

Insurance Bonds

1. Do you carry an Errors and Omissions Policy? No Yes

2. Do you carry a Fidelity Bond? No* Yes
 *If you do not have a Fidelity Bond, please provide a copy of your last fiscal year income statement and balance sheet.

3. Do you carry a Professional Liability Policy? No Yes

4. Do you require employee bonding? No Yes ; Which employees?

5. Have claims been made against any of these policies in the past two years? No Yes Provide details;

Financial

1. May we conduct an initial and ongoing financial review of your organization and/or principals using an independent agency, such as Equifax or Dun & Bradstreet? No Yes Explain:

2. Principal Banking relationship (to be used as a reference):

Name of Bank

Address

Telephone

Contact

Contact Title

Attachments

Please use this checklist and provide the following attachments. If one of these cannot be provided, please explain.

- Resumes of Officers, Directors, Owners, and Key Personnel
- Copy of each: Errors and Omissions Policy, Professional Liability Policy, and/or Bond now in effect
- If applicable, Last 2 Fiscal Year Income Statement and Balance Sheet
- Copy of TPA, MGA, Agency, Broker and Agent License for each applicable state
- Marketing Proposal
- Marketing Brochure
- Sales Literature on PPO and Managed Care
- Service Agreement
- Premium Account Flowchart/Description
- Claim Account Flowchart/Description
- Sample Billing
- Disclosure Form (P.T.E. 77-9)
- Evidence of Good Health Form
- Samples of Administrative Services Reports available to insurers and/or reinsurers
- Samples of Claims Reports available to insurers and/or reinsurers
- Sample Plan Document
- Additional Notes

I certify that the information on this application is accurate to the best of my knowledge and belief. I understand that a routine inquiry may be made of any or all of the individuals and firms noted herein as references.

SIGNATURE _____ Date _____

TITLE _____

