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| Anthem_B_0**APPLICATION FOR MCS/Jaa ADMINISTRATION**  **Commercial Client  Labor Client  TPA** | | | | | | | | | | | | | |
| **GROUP INFORMATION -** The Group applicant certifies the following information: | | | | | | | | | | | | | |
| Group’s Legal Name: | | | | | | EIN or Tax ID #: | | | SIC Code / Nature of Business: | | | | |
|  | | | | | |  | | |  | | | | |
| Street Address (P.O. Box is not acceptable): | | | | | | City: | | | County: | State: | | Zip: | |
|  | | | | | |  | | |  |  | |  | |
| **GROUP DECISION MAKER** | | | | | | | | | | | | | |
| Indicate the Name, Title, and Address of individual who will interface with the TPA on all major decisions regarding the account:  Name: Title: | | | | | | | | | | | | | |
| Address: City: State: Zip: | | | | | | | | | | | | | |
| Phone #: Fax: | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | |
| **GROUP DAY-TO-DAY CONTACT** | | | | | | | | | | | | | |
| Indicate the Name, Title, and Address of individual who will interface with the TPA on all day-to-day issues/ concerns regarding the account:  Name: Title: | | | | | | | | | | | | | |
| Address: City: State: Zip: | | | | | | | | | | | | | |
| Phone #: Fax: | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | |
| **BROKER CONTACT INFORMATION** | | | | | | | | | | | | | |
| Indicate the Name, Title, and Address of individual who will interface with the TPA on all day-to-day issues/ concerns regarding the account:  Name: Title: | | | | | | | | | | | | | |
| Brokerage Name: | | | | | | | | | | | | | |
| Tax ID: License Number: | | | | | | | | | | | | | |
| Address: City: State: Zip: | | | | | | | | | | | | | |
| Phone #: Fax #: | | | | | | | | | | | | | |
| Email: | | | | | | | | | | | | | |
| **PRODUCTS SOLD** | | | | | | | | | | | | | |
| Standard MCS PPO | | | | JAA | | | | | | | Front End | | |
| Blue View Vision | | | | MCS Dental Lease | | | | | | | DNAS Dental | | |
| IngenioRx  L&D | | | | EAP  ASO or Fully Insured Dental | | | | | | | Other: | | |
| **Form of Organization:** | | | | | | | | | | | | | |
| Corporation | Partnership | Union | Taft-Hartley Trust\* | | | | Government Entity (non-schools) | | | | | | JPA\* |
| Association\* | Proprietorship | MET\* | School Non-JPA\* | | | | Fraternal Order | | | | | | Other |
| \*Attach trust, JPA document or association by-laws, as appropriate. An Agreement/Policy will NOT be issued unless the document is received. | | | | | | | | | | | | | |
| **Client/TPA INFORMATION:** | | | | | | | | | | | | | |
| TPA Name: | | | | | | | | TPA Customer Service Phone #: | | | | | |
|  | | | | | | | |  | | | | | |
| Claims Address | | | | | City: | | | County: | | | State: | Zip: | |
|  | | | | |  | | |  | | |  |  | |

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| **Client/TPA ACCOUNT MANAGER:** | | | | | | | | | | | | | | | | | | | |
| Indicate the Name, Title and Address of individual who will interface with Anthem Blue Cross on all non-billing related issues (administrator/service issues contact): | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
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| **Client/TPA BILLING CONTACT:** | | | | | | | | | | | | | | | | | | | |
| Group Name (33 characters are available on the Billing Statement, customized ID cards.) | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
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| **Client/TPA DECISION MAKER:** | | | | | | | | | | | | | | | | | | | |
| Indicate the Name, Title and Address of individual who will interface with Anthem Blue Cross on all major decisions regarding the account: | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
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| **Client/TPA CLAIMS MANAGER:** | | | | | | | | | | | | | | | | | | | |
| Indicate the Name, Title and Address of individual who will interface with Anthem Blue Cross on all non-billing related issues (administrator/service issues contact): | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
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| **Client/TPA DAILY CLAIMS CONTACT:** | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
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| **Client/TPA CUSTOMER SERVICE MANAGER:** | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
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| **Client/TPA IT CONTACT:** | | | | | | | | | | | | | | | | | | | |
| Indicate the Name, Title and Address of individual who will interface with Blue Cross IT: | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
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| **On this account, the Client/TPA will perform the following administrative functions (check all that apply):** | | | | | | | | | | | | | | | | | | | |
|  | Premium Administration | | | | | | |  | | | Enrollment & Eligibility Services | | | | | | | | |
|  | Customer Service | | | | | | |  | | | Claims Processing | | | | | | | | |
|  | Overpayment Recovery/Claim Adjustments | | | | | | |  | | | ID Cards | | | | | | | | |
|  | Subrogation Services | | | | | | |  | | | Other (list below) | | | | | | | | |
| Client/TPA Submits Eligibility via: | | | | | | | |  | | | Hard copy | | | |  | Electronic Eligibility | | | |
| **Cite any additional functions performed by the Client/TPA:** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Client/TPA HIPAA DESIGNATED REPRESENTATIVE:** | | | | | | | | | | | | | | | | | | | |
| If you are a self-funded (ASO) group, please include the HIPAA designated representative information below: | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | Title: | | |  | | | | | | | | | |  |
| Address: | |  | | City: |  | | | | | | | State: | |  | | | Zip: |  |  |
| Phone #: | |  | | | | | Fax #: | | |  | | | | | | | | |  |
| Email: | |  | | | | | | | | | | | | | | | | |  |
|  | |  | | | | | | | | | | | | | | | | |  |
| **EFFECTIVE DATE/ANNIVERSARY DATE:** | | | | | | | | | | | | | | | | | | | |
| Effective Date: | | |  | | Anniversary/Renewal Date: | | | | | | | |  | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | |
| **ERISA?** | | | | | | | | | | | | | | | | | | | |

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| Is the plan subject to ERISA?  Yes  No | | | | | | | |
| **CAA Federal Negotiations and Independent Disputes (IDR):** | | | | | | | |
| Who is handling the Negotiations and IDR?  Anthem  TPA | | | | | | | |
| **EMPLOYEE ELIGIBILITY:** | | | | | | | |
| Eligible employees are: | Active full-time employees who work at least 30 hours per week. | | | | | | |
|  | Active full-time employees working: | | |  | Hours per week. | | |
| (check all that apply) | Part-time employees working: | | |  | Hours per week. | | |
|  | Retirees | | | | | | |
|  | Surviving Spouse | | | | | | |
|  | Surviving Dependent(s) | | | | | | |
| Total number of employees: | |  | Total number of employees ineligible: | | |  |  |
| Total number of active full-time eligible enrolling EEs: | |  | Total number of part-time or temp EEs: | | |  |  |
|  | | | | | | | |
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| **ID CARDS:** | | | |
|  | **CLIENT/TPA ISSUES IDENTIFICATION CARDS** (skip next two questions) | | |
|  |  | | |
| **WHERE WOULD YOU LIKE THE *INITIAL* IDENTIFICATION CARDS MAILED?** | | | |
|  | Employee’s residence (as indicated on enrollment application) | | |
|  | Other: |  |  |

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| **WHERE WOULD YOU LIKE THE *MAINTENANCE* IDENTIFICATION CARDS MAILED?** | | | |
|  | Employee’s residence (as indicated on enrollment application) | | |
|  | Other: |  |  |

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| **UNION EMPLOYEES?** | | | | | | |
| Are any employees covered under a collective bargaining agreement? | | | | Yes | No | |
| **PRIOR CARRIER COORDINATION:** | | | | | | |
| Please provide the name and phone number of an individual with your prior health carrier with whom we can coordinate for medical case management and transitional assistance. | | | | | | |
| Contact Name: |  | Phone Number: |  | | |  |
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| **ADDITIONAL COMMENTS:** | | | | | | | |
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| **SIGNATURES:** | | | | | | | |
| I understand and agree to all of the above. | | | | | | | |
| Dated at: |  | | on, |  | | |  |
| By: |  | |  |  | | |  |
|  | (Authorized Signature) | |  | (Print Name, Title of Officer, Partner or Proprietor) | | | |
| Authorized Broker of Record Signature: | |  | | | Anthem BC Broker #: |  |  |
|  | | | | | | | |