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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:**  |
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| **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: |       |  |
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| **EFFECTIVE DATE/ANNIVERSARY DATE:** |
| Effective Date: |       | Anniversary/Renewal Date: |       |  |
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| **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) |
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| **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 #: |       |  |
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