COMMUNITY CARE HEALTH

Large Group - Client Implementation Questionnaire

Effective Date (mm/dd/yyyy) _____

Email questionnaire to your Community Care Health representative or your broker.

1: GROUP INFORMATION

Indicate how the group name should appear on billing statement _____

Indicate any DBAs for the group_____

2: ENROLLMENT INFORMATION

Where would you like initial identification cards mailed?

☐ Employee's residence (as indicated on Enrollment Application)

☐ Group (as indicated on Application for Group Benefit Agreement), not recommended

Where would you like maintenance identification cards (i.e., new hires) mailed?

☐ Employee's residence (as indicated on Enrollment Application)

☐ Group (as indicated on Application for Group Benefit Agreement), not recommended

3: DECISION MAKER

This individual will interface with Community Care Health for major decisions regarding my account:

Name _____ Title _____

Street address_____ City _____ State _____ Zip _____

Phone no. _____ Fax no. _____ Email _____

4: DESIGNATED HIPAA REPRESENTATIVE

This individual is authorized to receive and securely handle protected health information – not specific to individual HIPAA authorizations for claims:

Name _____ Title _____

Street address_____ City _____ State _____ Zip _____

Phone no. _____ Fax no. _____ Email _____

5: GROUP ADMINISTRATOR

This individual will interface with Community Care Health on all non-billing related issues/service issues:

Name _____ Title _____

Street address_____ City _____ State _____ Zip _____

Phone no. _____ Fax no. _____ Email _____

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Company name (please print) _____

6: BILLING CONTACT

This individual will interface with Community Care Health on all billing related issues – if same as above, indicate "same":

Name _____ Title _____

Street address _____ City _____ State _____ Zip _____

Phone no. _____ Fax no. _____ Email _____

Group mailing address, if different than physical street address:

Street Address _____ City _____ State _____ Zip _____

Phone no. _____ Main fax no. _____

7: PAYMENT INFORMATION

Payment Information – Select for initial and recurring payment options:

☐ **7A. Client authorizes Community Care Health to withdraw the payment electronically from bank below: (please provide a voided check copy to address on 7C)**

Bank name _____

Transit routing no. _____ Account no. _____ Account Type: ☐ Checking ☐ Savings

I hereby authorize Community Care Health to debit our account for **payment by electronic transfer** for initial and recurring monthly premium payments. If this item is returned unpaid, I may be charged an additional fee for each payment returned for insufficient funds.

Authorized signer on account name _____ Phone no. _____

Authorized signature **X** _____ Date _____

☐ **7B. Client submits payment to Community Care Health electronically to bank below:**

Bank name Wells Fargo

Account name Community Care Health

Transit routing no. 121000248 Account no. 4122337181

☐ **7C. Client submits payment to Community Care Health by mail to address below:**

Community Care Health
Attn: Accounting Dept.
45 River Park Place West, Suite 501
Fresno, Ca 93720

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Company name (please print)

_____

8: ADDITIONAL INFORMATION

Third-Party Administration (TPA)? ☐ **Yes** ☐ **No** If "No," skip to next sub-section. Additional forms required for multiple TPAs.

TPA name _____ Title _____

Street address _____ City _____ State _____ Zip _____

Contact/Title _____ Phone no. _____ Email _____

Is TPA also the broker? ☐ Yes ☐ No

On this account, the TPA will perform these functions (check all that apply):

☐ Premium administration ☐ Enrollment and eligibilit services ☐ COBRA ☐ Other: _____

If the TPA collects premiums, indicate TPA's premium remittance method: ☐ Remits net ☐ Remits gross

Administration fee is: ☐ None ☐ % of premium ☐ $_____ per subscriber ☐ $_____ per member

How is the administration fee to be paid?

☐ Directly and separately by the group

☐ TPA nets out fee from collected premium

☐ Monthly payment by Community Care Health after Community Care Health receives gross premium

Non-Community Care Health health plan employer contributions

If a non-Community Care Health health plan is offered alongside Community Care Health, the employer contribution for the non-Community Care Health health plan is:

Employee: _____% Dependent: _____ %

Do you have any Cal-COBRA eligibles and enrollees?

If "Yes," please be sure to send open enrollment information, including Cal-COBRA enrollment forms to these members (responsibility of the employer group, per California law). ☐ Yes ☐ No

Electronic enrollment options for ongoing additions, maintenance changes and terminations (Our goals include delivering an exceptional experience and being easy to do business with. To provide the best service, members need to have instant access to time-sensitive information. Please include employee email addresses.)

Standard method for **initial** enrollment:

☐ Census Tool: (Recommended. Community Care Health will supply a customized Excel document.)

☐ 834 File Format: (4-6 weeks set-up time required.) TPA information required if this option is selected.

Standard method for **ongoing** enrollments and maintenance changes:

☐ 834 File Format: (Recommended for groups 500 or more in size. 4-6 weeks set-up time.)

☐ Comprehensive Enrollment Wizard (CEW)

9: CERTIFICATION AND INDEMNIFICATION

The employer certifies and acknowledges that no attempt will be made to re-identify the individuals that are the subjects of the data provided as a result of a request for De-identified[1] or Summary Health Information.[2] In addition, the employer further certifies that it will require any downstream vendors or other parties that may receive De-identified and/or Summary Health Information at the request of the employer to certify that they will also make no attempt to re-identify the individuals that are subject to the data provided. Any attempt by a recipient to re-identify the data could constitute the use, disclosure, or maintenance of protected health information under HIPAA which would require recipient to meet all requirements for safeguarding protected health information and/or personal information set out in federal and/or state law. Recipient will indemnify and hold harmless Community Care Health and any Community Care Health affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any nonpermitted or prohibited use or disclosure of re-identified protected health information by recipient or any subcontractor, agent, person or entity under recipient's control.

10: CLIENT AUTHORIZATION

Date form submitted to Community Care Health:_____ First proposed enrollment meeting date:_____

Print name _____ Title _____

Authorized signature **X** _____ Date _____

1 De-identified Data has all 18 identifiers removed as required by HIPAA (§164.514) and that cannot be used alone or in combination with other information to re-identify individual(s) who are subjects of that data.
2 Summary Health Information summarizes claim data for an employer group to meet the requirements of De-identified Data that is aggregated to a five-digit ZIP code.