



**Provider Excess Request for Proposal**

Insurance Effective Date: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ Fax: \_\_\_\_\_

Federal Tax ID#: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Current Insurer: \_\_\_\_\_ Proposal Due Date: \_\_\_\_\_

**EXCESS LOSS COVERAGE – Data and Information Request**

1. **Type of Organization** -- \_\_\_ Hospital \_\_\_ Group Practice \_\_\_ IPA \_\_\_ PHO \_\_\_\_\_ Other (describe)
2. **Contracting Information** – Provide a copy of the most current division-of-financial-responsibility matrix for each contracted managed care organization (MCO) by member type. For Medicaid members, break out by sub-category. Indicate if there have been significant changes in the last 3 years. Describe any sub-capitation arrangements for the last 3 years.
3. **Coverage Being Requested** – Please list the services for which coverage is being requested (e.g., inpatient hospital services, outpatient facility services, physician services, prescription drugs, etc.). Include requested options for deductibles, average daily maximum limitations, coinsurance, annual/lifetime maximum benefits, and physician fee schedule/accumulation basis, if applicable.
4. **Three Years of Claims Detail** – By insurance year for the last three years, by member type, for any member whose claims exceed 75% of the lowest requested deductible. It should also include data for covered services being requested in the insurance proposal (i.e., inpatient only, inpatient and outpatient, professional services, etc.) Column headings: Member ID, Member Type, MCO, Primary Diagnosis Code, Diagnosis Description, Dates of Service, Provider Name, Total Charges, and Total Paid. Include information on potentially large cases that are known but may not be reflected in the claim report.
5. **Three Years of Member Months** – Provide this information by month by member type.
6. **Tertiary Care Services** – Provide the facility names and contracted rates for tertiary-care services that are your financial responsibility, including information on outliers or minimum payment provisions. Indicate if there are tertiary-care services for which there aren't contracted rates and where those services are rendered.
7. **Non-Tertiary-Care Services** – Provide a summary of contracted facilities and rates.
8. **Historical Costs** – Provide days-per-thousand and average-cost-per-day data for the past 3 years by member type.
9. **Non-Network Services** – Provide the percentage of non-network utilization for hospitals and professional services. List any physician specialties that are not in the network.
10. **Medical Management** – Describe the utilization and case management programs, including the process for identifying members for case management and the average case manager caseload. Describe the measure taken to prevent inpatient hospitalizations and extended confinements.
11. **6. Copy of Current Policy** – Provide a copy of the current excess loss policy and outline the coverage for the previous two years.

I hereby certify that the information provided above is complete and accurate. I understand that in the event Zurich American Insurance issues the insurance coverage being requested, the policy provisions and premium rates will be based on the information provided in this Request for Proposal and any supplementary information. If such information is later found to be incomplete or inaccurate, Zurich may, at its discretion, consider that there has been a material change and may adjust premium rates accordingly.

**Completed By:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Broker:** \_\_\_\_\_

**Broker of Record: Yes** \_\_\_\_ **[Number of Years as BOR**\_\_\_\_] **No** \_\_\_\_

**Commission Amount:** \_\_\_\_\_

**Please return the completed questionnaire to:**

Summit Reinsurance Services, Inc.  
7030 Pointe Inverness Way, Suite 350  
Fort Wayne, IN 46804  
Phone: (260) 469-3000  
Fax: (260) 469-3014