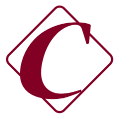


COMMUNITY CARE HEALTH

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 ____________________

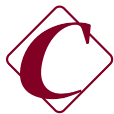
5: GROUP ADMINISTRATOR

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 ____________________

 COMMUNITY CARE HEALTH

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:

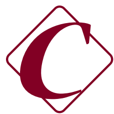
Bank name Wells Fargo

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
7370 N. Palm Ave., Ste. 101
Fresno, CA 93711



COMMUNITY CARE
HEALTH

Client Implementation Questionnaire

Company name (please print)

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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:

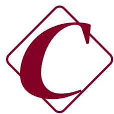
Census Tool: (Recommended. Community Care Health will supply a customized Excel document.)

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)



Company name (please print)

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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.