Community Health Alliance

Account Set- Up Information
2021

The following is a list of information CHA needs for EACH new employer group:

1. **Completed** Employer Group Information Form (EGI) 1 week prior to effective date

2. Copy of EOB that shows where the CHA discount will be listed

3. Copy of the **Drafted** I.D. card with the appropriate CHA Block style logo
   This is to be on the Front of the card

4. Summary of Benefits for the employer plan

5. Initial eligibility list of employees

6. Timely Claims Filing Limit

7. Please specify if you are doing the claims run-in (Additional fees apply if CHA is doing the repricing).

*Please note that CHA requires a draft of the i.d.card before it is printed to eliminate issues of incorrect logos on I.D. cards. The i.d. card must be approved by CHA.

If you have questions, please contact:

Barbara Garrett
New Accounts/CHA Renewals
Phone: 574-647-1845
Fax: 574-647-1825
bgarrett@beaconhealthsystem.org

DATE PREPARED_____**EFFECTIVE DATE:** _____

COMMUNITY HEALTH ALLIANCE
EMPLOYER GROUP INFORMATION SET-UP SHEET

Employer/Subsidiaries:_____**Phone:** **Group#**_____

Address:_____**City:**_____**State/Zip:**_____

Contact:_____**Phone:**_____**# of Employees choosing CHA :** _____
# of Employees choosing other network: _____
Contact Email:_____ **Total # of Employees eligible:**_____
Program Sold:_____**Network**
_____**Utilization Review**
_____**Case Management** **Dual Network**_____
_____**Repricing** **(If so, 2nd network)** _____

****FOR ELIGIBILITY & BENEFIT INFORMATION:**

Insurance Company/TPA:

Contact:_____**Phone:**_____**Fax**:_____

Address:_____

City: _____**State:**_____ **Zip:** _____

****SEND CLAIMS TO:** **Filing Limit (please circle):** **3mos, 6mos, 9mos, 12mos**
Other:_____
___ **Check if CHA is doing the repricing (and than below put the address where repriced claims are to be sent).**

Name:_____**Address:** _____

City:_____**State/Zip:**_____**Phone:** _____

Fax:_____
Electronic claims submission: **Yes**_____**No**_____ **If yes: Access Via** _____
Please specify who is to do the run-in and for how long*_____
***If CHA is doing the run-in the cost is one month's access fees.**

****PRECERTIFICATION:**
Contact:_____**Phone:**_____
Inpatient_____**Outpatient**_____ **All Other**_____

****BENEFIT SUMMARY:**
HSA:_____ **HRA:**_____ **HD/HP:**_____ **Wellness:**_____
Deductible:_____ **Co-insurance:**_____
ER Co-pay: _____ **Pharmacy:**_____
Office Visits: _____ **Hospital**: _____
Other(carveouts?):_____**Other group health plans offered if known:**_____

****MISCELLANEOUS INFORMATION NEEDED:***
*** Please attach a copy of the EOB, Employer Group I.D. and Benefit Summary. ****

COMMUNITY HEALTH ALLIANCE

COMPANY: _____

FEES:

Access Fee: _____

Run-In Fee (One month's access): _____

Repricing Fee: _____

UR Fee: _____

Case Mgt. Fee: _____

CONTACTS:

1.) **Access Fee Contact Person:** _____

Access Fee Contact Phone: _____

Access Contact Email: _____

2.) **Claim Report Contact Person/Savings Report:** _____

_____

(only needed if TPA is repricing)

Claim Report Phone: _____

Claim Report Email: _____

3.) **UR/CM Report Person/Contact:** _____

(if applicable)

UR/CM Report Phone: _____

UR/CM Report Email: _____

NETWORK:

Wrap Acct. (if applicable): _____

Dual Networks (if applicable): _____

Network Replaced: _____ **TPA Replaced:** _____

BROKER:

Broker/Consultant: _____

Broker Agency: _____

Broker Phone: _____

INTERNAL USE ONLY:

Elkhart General Hospital Discount: _____

Memorial Hospital Discount: _____