The following is needed for each new employer group:

- **Completed** Employer Group Information Form (EGI) 1 week prior to effective date
- Copy of EOB that shows where the CHA discount will be listed
- Copy of the **drafted** ID card with the appropriate CHA block style logo
- Summary of Benefits for the employer plan
- Initial eligibility list of employees
- Timely claims filing limit
- Please specify if you are doing the claims run-in (additional fees may apply if CHA is repricing)

Please note: CHA requires a draft of the ID card before it is printed to eliminate issues of incorrect logos on ID cards. The ID card must be approved by CHA.

Contact for New Accounts/CHA Renewals:

Barbara Garrett
Executive Director, Value Based/Care Coordination

Beacon Health System
3245 Health Drive, Granger, IN 46530
P: 574.647.1845
M: 219.871.9137
bgarrett@beaconhealthsystem.org

COMMUNITY HEALTH ALLIANCE

DATE PREPARED _____ **EFFECTIVE DATE** _____

EMPLOYER

Name		Group Number
Address		
City	State	Zip Code
Contact Name		
Phone	Email	

Subsidiary (if applicable)

Name		Group Number
Address		
City	State	Zip Code
Contact Name		
Phone	Email	

Dual Network ☐ Yes ☐ No

2nd Network _____

Total Eligible Employees_____

Number of Employees Electing CHA _____

Number of Employees Electing Other Network _____

Program Sold

- ☐ Network
- ☐ Utilization Review
- ☐ Case Management
- ☐ Repricing

FOR ELIGIBILITY AND BENEFIT INFORMATION

Insurance Company/TPA Name		
Address		
City	State	Zip Code
Contact Name		
Phone	Fax	

Filing Limit ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other _____

SEND CLAIMS TO:

CHA is repricing ☐ Yes ☐ No

If yes, address where repriced claims are sent:

Name		
Address		
City	State	Zip Code
Phone	Fax	

Electronic Claims Submission ☐ Yes ☐ No If yes, access via _____

Run-In Who processes _____How long _____

If CHA is doing run-in the cost is one month's access fees.

PRECERTIFICATION

Contact Name	Phone

☐ Inpatient ☐ Outpatient ☐ All Other _____

BENEFIT SUMMARY

☐ HSA ☐ HRA ☐ HDHP ☐ Wellness

	Plan 1		**Plan 2**	
	In Network	Out of Network	In Network	Out of Network
Deductible				
OOP Max				
Coinsurance				
PCP/SPC				
UC				
ER				
Inpatient Services				
Outpatient Services				
Rx				

Other (Carveouts)_____

Other group health plans offered if known _____

Please attach a copy of the following:

- **EOB**
- **ID Card**
- **Benefit Summary for each plan**

COMMUNITY HEALTH ALLIANCE™

GROUP NAME _____

FEES

Access Fee	
Run-In Fee (one month's access)	
Repricing Fee	
UR FEE	
Case Management Fee	

CONTACTS

- Access Fee Contact

Name	
Phone	Email

- Claim Report Contact/Savings Report (only needed if TPA is repricing)

Name	
Phone	Email

- UR/CM Report Contact

Name	
Phone	Email

NETWORK

Wrap Acct (if applicable)	
Dual Network (if applicable)	
Network Replaced	
Carrier/TPA Replaced	

AGENT/CONSULTANT

Name	
Agency	
Phone	Email

INTERNAL USE ONLY

Elkhart General Hospital Discount	
Memorial Hospital Discount	

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