2002

The
HMO/PPO Directory

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Important HMO/PPO Survey

Accurate listings in this directory represent your health plan to the entire industry. It's timely… *it's important*! Please take a moment to make corrections and additions to your existing directory listing. Thank you!

The 14th Edition of the ***HMO/PPO Directory***, formerly published by **Medical Economics/Thomson Healthcare**, will be reintroduced in October 2001 by **Sedgwick Press, an imprint of Grey House Publishing**. Take advantage of this opportunity to profile your organization to the insurance industry, prospective members, and professionals in the medical industry. The ***HMO/PPO Directory*** is filled with detailed information on over 600 HMOs and 1,000 PPOs across the Country. Below is your ***free listing*** as it appeared in the 2001 edition of the ***HMO/PPO Directory*.** We ask that you take a few moments to verify this information for accuracy, crossing out inaccurate information and making changes within this document as necessary. If you have additional information, please fax that to us as well. *There is no charge for your listing, nor are you required to purchase the work.*

HealthPlan Information (Please Print)

Health Plan Name:_____ **For Profit:** _____ **Not for Profit:**_____ **Year Founded:**_____

Is the health plan: **Physician Owned: (Y / N)**_____ **Owned by an Integrated Delivery Network (IDN): (Y / N)** _____
Federally Qualified: Yes_____ **No**_____**Year:** _____ **Web Site URL:** _____

Health Plan Address: _____ **City:**_____ **State:** _____ **Zip:**_____
Telephone: _____ **Toll Free:** _____ **Fax:**_____ **E-Mail:**

Mailing Address: _____ **City:**_____ **State:**_____ **Zip:**_____

If a subsidiary, **Parent Company Name:** _____

# of Affiliated Hospitals: _____ **# of Physicians: Primary:** _____ **# of Referral/Specialty Physicians:** _____

Current Member Enrollment: _____ **As of what Date:** _____

HealthPlan and Services Defined (Please ✓all that apply.)

Plan Type: ____HMO _____PPO _____POS ____TPA **Model Type: _____Staff ____IPA ___Group ____Network ___PHO**

Other(Please list): _____ **Other** (Please list):_____

Plan Specialty
(✓all that apply)

- ____ASO
- ____Behavioral Health
- ____Chiropractic
- ____Dental
- ____Disease Mgmt
- ____EPO
- ____Lab
- ____MSO
- ____PBM
- ____Vision
- ____Radiology
- ____Worker's Comp
- ____UR
- Other: _____

Benefits Offered:
(✓all that apply)

- ____ Behavioral Health
- ____ Chiropractic
- ____ Complementary Medicine
- ____ Dental
- ____ Disease Management
- ____ Home Care
- ____ Inpatient SNF
- ____ Long-Term Care
- ____Physical Therapy
- ____ Podiatry
- ____ Prescription
- ____ Psychiatric
- ____ Transplant
- ____ Vision
- ____ Wellness
- ____ Workers Comp
- ____ AD&D
- ____ Life
- ____ LTD
- ____ STD
- Other: _____

Do you offer Demand Management Patient Information Services? (Y / N) _____ If yes, please list the top 5 services offered:

1) _____ 2) _____ 3) _____ 4)_____ 5) _____

Type of Coverage (Please ✓ all that apply.)

___ Commercial ___ Individual ____ Indemnity ____ Medicare ____Supplemental Medicare ____ Medicaid ___ Catastrophic ____ Other

***Identify Other*: _____**

___ Catastrophic: If yes, note Max Benefit: ___ unlimited ___ varies per case ___ $1M ___$2M Other: _____

Type of Payment Plans Offered (Please ✓ all that apply.)

_____Point of Service (POS) ____ Discounted Fee For Service (DFFS) ____ Capitated ___ Fee for Service (FFS) ___ Comb. FFS & DFFS

Geographical Areas Served (by State and County)

Subscriber Information

	Average Monthly Fee Per Subscriber (Employee + Employer Contribution)	Annual Average Deductible Per Subscriber
Employee Only (Self)	_____	_____
Employee & 1 Family Member	_____	_____
Employee & 2 Family Members	_____	_____
Medicare	_____	_____

Average Subscriber Co-Payment

Primary Care Physician _____ Non-Network Physician _____ Prescription Drugs _____Hospital ER _____

Home Health Care _____ Note Max. Days Covered for Home Health Care _____
Nursing Home _____ Note Max. Days Covered for Nursing Home _____

Qualifications Needed to Become a Network Physician

Minimum Years of Practice _____ Pre-Admission Certification (Y / N) _____

Peer Review Type (Please ✓ all that apply)

Utilization Review _____ 2nd Surgical Opinion _____ Case Management _____

Accreditation Certification (Please ✓ all that apply)

_____ Accreditation Association for Ambulatory Health Care (AAAHC)
_____ Joint Commission on Accreditation of Health Care Organizations
_____ American Accreditation Healthcare Commission (formerly URAC)
_____ American Accreditation Program, Inc. (AAPI)
_____ National Committee for Quality Assurance
(Please Specify) _____

Do you publish and distribute a Report Card on your organization? (Y / N) _____

Catastrophic Illness Regulations (Please ✓ all that apply)

JCAHO Accreditation _____ Pre-Admission Certification _____
Medicare Approved _____ State Licensure _____
Utilization Review _____ Quality Assurance Program _____

Key Personnel (Please PRINT First and Last Name)

Department	First Name	Last Name	BSN, MD, etc.	Head of Department	Phone	E-Mail Address
Administration				President/CEO		
Administration				Chief Financial Officer		
Administration				Chief Operations Officer		
Claims						
Network Contracting						
Credentialing						
Dental						
In-House Formulary						
Marketing						
Materials Management						
Medical Affairs						
Member Services						
Information Systems						
Provider Services						
QA/UR						
Sales						

Financial Information

Income Statement	**1996**	**1997**	**1998**	**1999**	**2000**
Revenues					
Net Income					
Medical Loss Ratio Total					
Administrative Expense Ratio					
Membership Enrollment Total					
Patient Complaints filed with the State Ins. Comm.:					

Average Claim Compensation

Physician's Fees Charged (give %): _____ **Hospital's Fees Charged (give %):** _____

Managed Care and Other Business Partners

Please list your specialty managed care partners. (e.g. Behavioral Health partner's name):

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

Do you enter into contracts with Regional Business Coalitions? (Y / N) _____ If yes, please list them:

1) _____ 2) _____ 3) _____

4) _____ 5) _____

Employer References

Please list the top 5 employer references (employers contracted with your Healthplan):

Employer Name: _____

Employer Name: _____

Employer Name: _____

Employer Name: _____

Employer Name: _____

In case *we* have questions: Completed by (Print): _____ **Title:** _____

Phone: _____ **E-Mail:** _____ **Date:** _____

YES, I would like to *PREVIEW* the *HMO/PPO Directory* for 30 days (no obligation to purchase). Cost $250

Do YOU have Questions? Contact Elizabeth Whalen, Product Manager at (800) 562-2139 x134 or ewhalen@greyhouse.com.