



### THIRD PARTY CLAIMS ADMINISTRATOR QUESTIONNAIRE

1. Name of Firm \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Telephone \_\_\_\_\_ Fax \_\_\_\_\_  
 Web Address \_\_\_\_\_ Email Address \_\_\_\_\_

2. Ownership of Firm:  Corporation  Partnership  Sole Proprietor  Sub-Chapter S Corporation  
 Tax Identification Number: \_\_\_\_\_

3. Date firm began operation as a Claims Administrator \_\_\_\_\_

4. How many individuals are currently employed? Part-Time \_\_\_\_\_ Full-Time \_\_\_\_\_  
**Please provide a current organizational chart.**

5. Key Personnel

a. Top Three Executives: **(please attach resumes)**

Name	Title	Length of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Senior Claims Person: **(please attach resume)**

Name _____	Title _____	Length of Service _____
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c. Principal Contact: **(please attach resume)**

Name _____	Title _____	Length of Service _____
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6. a. Please list the Stop Loss Carriers that have approved your firm:

Carrier Name	Date of Approval	No. of Cases	Preferred Status?
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

(if additional space is needed, please attach a supplemental list)

b. Do you have binding authority or underwriting authority for any of the carriers listed above?

Yes  No

If yes, please provide details \_\_\_\_\_  
 \_\_\_\_\_

c. Number of stop loss markets utilized for each quote request? \_\_\_\_\_

7. Breakdown of cases you currently administer:      No. of Cases                      No. of Employees

a. Fully Insured    \_\_\_\_\_                      \_\_\_\_\_

b. Self Insured    \_\_\_\_\_                      \_\_\_\_\_

c. METs, Associations or Unions                      \_\_\_\_\_                      \_\_\_\_\_

8. Enrollment cards and eligibility records are maintained by:

TPA               Employer       Other (specify) \_\_\_\_\_

9. Eligibility is updated how often? \_\_\_\_\_

10. Can you provide census and premium funding data electronically?       Yes       No

11. Number of claims examiners:      Part-Time \_\_\_\_\_                      Full-Time \_\_\_\_\_

12. a. Claims processing is:       Manual       Automated

b. System is:       Owned       Leased       Timeshared  Other

If automated, briefly describe the system (hardware, software, version, last updated, etc): \_\_\_\_\_

c. Does your system check for any of the following? Please check all that apply:

Possible duplicate claim       Overage dependent                       Unbundling of charges

Procedure upcoding                       Possible catastrophic diagnosis                       Claims after coverage termination

13. What is your claim turnaround time goal? \_\_\_\_\_       Business Days       Calendar Days

What was your actual claim turnaround average for the last 6 months? \_\_\_\_\_

On what basis is this determined (received to processed, received to paid, etc)? \_\_\_\_\_

14. Average number of claims processed per day / per examiner? \_\_\_\_\_

15. a. Are there procedures set up for internal audits of examiners?       Yes       No

If yes, how frequently are audits performed: \_\_\_\_\_

b. What is measured:      Financial Accuracy                      Procedural Accuracy                      Payment Accuracy

Yes       No                       Yes       No                       Yes       No

c. If measured, what are your goals/standards for accuracy?

Financial Accuracy

Procedural Accuracy

Payment Accuracy

d. What were the average results in each category for the past 6 months?

Financial Accuracy

Procedural Accuracy

Payment Accuracy

16. Do your claim examiners have established monetary authority limits? If so, what are they and what is the review process for claims exceeding an examiner's authority limit? \_\_\_\_\_

17. a. What is the source of your Usual & Customary expense determinations?

Ingenix/HIAA    Ingenix/MediCode    Developed In-house    Other

b. How often are your Usual & Customary guidelines updated? \_\_\_\_\_

c. What percentile is most commonly utilized:  75<sup>th</sup>    80<sup>th</sup>    85<sup>th</sup>    90<sup>th</sup>    95<sup>th</sup>    Other

18. How are claim files maintained?  Paper files by examiner    Batch file    Microfilm/fiche

Electronic Image    Other (specify) \_\_\_\_\_

19. Is the following information maintained for each claim?

a. Enrollment & eligibility dates    Yes    No      f. Incurred Date       Yes    No

b. Student status       Yes    No      g. Received Date       Yes    No

c. Coordination of benefits Info    Yes    No      h. Processed Date       Yes    No

d. Medical bills, claim calculation    Yes    No      i. Paid Date       Yes    No

worksheets & medical records

e. Other party liability investigation    Yes    No  
documentation (e.g. Subrogation, Workers' Comp)

20. Do you have the ability to report the following information?

a. Extracontractual Payments       Yes    No      Maintained by:  Log    System    Other

b. Recovered Overpayments       Yes    No      Maintained by:  Log    System    Other

c. Unrecovered Overpayments       Yes    No      Maintained by:  Log    System    Other

d. Denied Payments       Yes    No      Maintained by:  Log    System    Other

21. Check Production is:   a.  Manual       Automated

b.  Daily       Weekly       Other (specify) \_\_\_\_\_

c. What methods are generally used to fund your clients' self-funded plan accounts?

\_\_\_\_\_

d. Are checks automatically distributed or held for adequate funding? \_\_\_\_\_

22. Do you provide the following services for your clients internally? If Yes, please provide the name of the contact at your firm and attach resume. If No, please provide the name and phone number of the vendor/firm you use:

Pre-Admission Certification     Yes    No    Contact Name \_\_\_\_\_

Vendor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Utilization Review     Yes    No    Contact Name \_\_\_\_\_

Vendor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Concurrent Review     Yes    No    Contact Name \_\_\_\_\_

Vendor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Large Case Management     Yes    No    Contact Name \_\_\_\_\_

Vendor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Organ Transplant Network     Yes    No    Contact Name \_\_\_\_\_

Vendor Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

23. Do you have any Managed Care Programs negotiated directly with providers?     Yes    No  
If Yes, please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Do you have procedures in place to negotiate discounts on non-networks claims?     Yes    No  
If Yes, please describe the procedures, vendors, & fees \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Do you have the ability to "flag" and report any claim that has reached or exceeded 50% of the specific deductible and/or any claim that has a diagnosis with the potential to become a large claim?

a. By amount paid     Yes    No    b. By diagnosis     Yes    No

c. By days inpatient     Yes    No

26. Do you monitor claims for potential other party liability (subrogation)?     Yes    No  
If Yes, is this functioned handled internally or outsourced?     Internally    Outsourced  
If outsourced, who is your vendor? \_\_\_\_\_  
\_\_\_\_\_

27. Is your firm a member of any professional societies:     Yes    No  
If Yes, please specify \_\_\_\_\_  
\_\_\_\_\_

28. Has any Insurance Company or Carrier withdrawn their claims paying authority or TPA approval?

Yes  No

**If Yes, please provide details as an attachment.**

29. Has your firm or any of your employees ever had a lawsuit or Insurance Department complaint brought against them?  Yes  No **If Yes, please provide details as an attachment.**

30. Is your firm audited annually by an outside independent auditor?  Yes  No  
If Yes, please provide date of audit & name of auditing firm \_\_\_\_\_

31. Is your firm in a state(s) that requires TPAs be licensed?  Yes  No  
**If Yes, please attach a copy of your current license(s).**

32. Does your firm carry:

**DOCUMENTATION OF CURRENT POLICIES MUST BE ATTACHED:**

a. Errors and Omissions Coverage?  Yes  No **If Yes, please attach declaration page.**  
Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Limit of Liability \_\_\_\_\_ Term \_\_\_\_\_

b. Commercial/General Liability Coverage  Yes  No **If Yes, please attach declaration page.**  
Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Limit of Liability \_\_\_\_\_ Term \_\_\_\_\_

c. Fidelity Bond  Yes  No **If Yes, please attach declaration page.**  
Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Limit of Liability \_\_\_\_\_ Term \_\_\_\_\_

d. Fiduciary Liability Coverage  Yes  No **If Yes, please attach declaration page.**  
Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Limit of Liability \_\_\_\_\_ Term \_\_\_\_\_

33. Has your firm ever filed an Errors & Omissions or Fidelity Bond/Employee Dishonesty claim?  Yes  No  
**If Yes, please attach details.**

34. Who does your firm develop business through:  
Agents/Brokers \_\_\_% Salaried Employees \_\_\_% Principals \_\_\_% Others \_\_\_%

35. Who prepares Plan Documents and Summary Plan Descriptions for your clients? \_\_\_\_\_

**Please attach a copy of your standard Plan Document wording.**

Does your firm review PDs and SPDs to ensure compliance with current regulations?  Yes  No

How often are PDs and SPDs updated? \_\_\_\_\_

36. Do you have the ability to provide claims data broken down by PPO vs non-PPO utilization?  Yes  No  
If Yes, can you provide the data by PPO if there are multiple PPOs utilized?  Yes  No

37. Are you now capable of receiving electronic claims directly from providers?  Yes  No  
If Yes, what percentage of incoming claims are you receiving electronically? \_\_\_\_\_  
If No, when do you expect to be ready to receive electronic claims from providers? \_\_\_\_\_

38. Please describe the actions that your firm has taken in response to the HIPAA privacy and security requirements. Have written privacy and security compliance policy and procedure statements been developed?  
 Yes  No **If Yes, please supply a copy of these documents.**

39. Please provide a description of any significant changes projected for your organization, including mergers and/or acquisitions, system changes or upgrades, and the like:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF THE ABOVE INFORMATION IS CORRECT. I ALSO UNDERSTAND THAT AS A MATTER OF PROCEDURE A ROUTINE INQUIRY MAY BE MADE OF ANY OR ALL OF THE INDIVIDUALS AND FIRMS NOTED ABOVE AS REFERENCES IN ORDER TO ASCERTAIN APPROVING THIS FIRM AS A QUALIFIED THIRD PARTY ADMINISTRATOR.

Signature of Principal, Partner or Officer: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Print Title: \_\_\_\_\_  
Date: \_\_\_\_\_

**Mail To: TRU Services, LLC  
100 Cummings Center, Suite 220G  
Beverly, MA 01915  
Phone: 978-564-0200  
Fax: 978-564-0201**

### ATTACHMENTS

- Please attach the following to this questionnaire.
- Current Organizational Chart and Resumes of Key Personnel
  - State Administrator (TPA) License(s), if applicable
  - Declaration Page for E&O Coverage
  - Declaration Page for Commercial/General Liability Coverage

- Declaration Page for Fidelity Bond
- Declaration Page for Fiduciary Liability Coverage
- Details of all suits filed against E&O, Fidelity Bond/General Liability, or Fiduciary Liability Coverages
- Details of any withdrawals of claim paying authority
- Details of any Insurance Department complaints or lawsuits
- Details of any on-site audit results
- Sample Plan Document
- HIPAA Action Plan and Compliance Documents