NEW YORK STATE DEPARTMENT OF HEALTH
Division of Health Care Financing

Third Party Administrator (TPA) or Administrative Services Only (ASO) Status Change

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

This form must be completed if an electing payor is adding or changing their TPA/ASO.

Effective Date:_____

PAYOR INFORMATION:

Payor Name: _____ Payor FEIN: _____

Contact Person: _____ Phone #: _____

Type of Status Change (check appropriate box):

☐ **Additional TPA/ASO** (complete Section II only)

☒ **Changing TPA/ASO** (complete Sections I, II & III)

I. PREVIOUS TPA/ASO INFORMATION:

TPA/ASO Name: _____ TPA/ASO FEIN: _____

II. NEW or ADDITIONAL TPA/ASO INFORMATION:

TPA/ASO Name: Allied Benefit Systems, Inc. TPA/ASO FEIN: 36-308605C

Address: 200 West Adams, Suite 500

Chicago, IL 60606

TPA/ASO Contact Person: Tammy Blank TPA/ASO Phone #: 312-906-8080

III. CHECK ONE OF THE FOLLOWING:

☐ Previous TPA/ASO will continue to process claims and file reports for all dates of service prior to the change for a period of one year following the end of the year in which the change in TPA occurred or until all such claims have been adjudicated, at which time a final monthly report with a copy of this form indicating same will be filed.

☐ All self-insured claims that previous TPA/ASO was responsible for have been adjudicated effective_____.

☑ New TPA/ASO is assuming responsibility for all pending claims and HCRA reporting requirements.

Signature of Payor: _____ **Date:** _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: _____

FEDERAL EMPLOYER IDENTIFICATION # (FEIN): _____

PAYOR NAME: _____

D/B/As (IF APPLICABLE): _____

ADDRESS: _____

_____

CONTACT PERSON: _____

PHONE #: _____

E-MAIL ADDRESS: _____

If the above referenced entity is a payor that utilizes a third-party administrator (TPA)/administrative services only (ASO) for claims processing, please provide the following information:

TPA/ASO NAME: Allied Benefit Systems, Inc.

TPA/ASO FEIN: 36-308605C

By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory[1], or ambulatory surgery center) by product line;

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

[1]For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).

5. the Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments have been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature_____ **Title**_____
Chief Financial Officer or Duly Authorized Individual

Date_____

Note: Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Payor Election Application

COVERAGE INFORMATION (See Attached For Further Explanation)

PAYOR NAME:_____ **FEDERAL ID#:**_____

TPA/ASO NAME: Allied Benefit Systems, Inc. **TPA/ASO FEDERAL ID#:** 36-308605C

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE

	TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE:									
		INDEMNITY COVERAGE	HMO NON-MEDICAID OR NON-NYS MEDICAID COVERAGE	SELF-INSURED COVERAGE	NEW YORK STATE HMO/PHSP MEDICAID COVERAGE	NEW YORK STATE GOVT PROGRAM W/INPATIENT COMPONENT & NYS LOCAL GOVT CORRECTIONS	NEW YORK STATE WORKERS COMPENSATION LAW COVERAGE	NEW YORK STATE MOTOR VEHICLE REPARATIONS ACT COVERAGE	NEW YORK STATE VOLUNTEER AMBULANCE WORKER'S BENEFIT LAW COVERAGE	NEW YORK STATE VOLUNTEER FIREFIGHTERS' BENEFIT LAW COVERAGE	OTHER COVERAGE
1	Corporations Organized & Operating in accordance with Article 43 of the NYS Insurance Law										
2	Corporations that are Commercial Insurers licensed in New York State										
3	Corporations Organized & Operating in accordance with Article 44 of the NYS Public Health Law, not incorporated as Commercial Insurers or under Article 43 of the NYS Insurance Law										
4	Self-Insured Fund with No Third Party Administrator/Administrative Svcs Only Organization for Claims Processing										
5	Self-Insured Fund with a Third Party Administrator/Administrative Svcs Only Organization for Claims Processing			X							
6	New York State Governmental Agency/ New York State Local Government										
7	Other (please explain below): Includes: State/Local Governments outside New York for Medical Assistance Programs; insurers licensed outside New York State, authorized to write OTHER than Accident and Health										
8	HMOs and insurers licensed outside New York State, authorized to write Accident and Health										

Explanation of "Other" Payor Identification

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

☐ **New Request** ☐ **Revision to Existing Account**

Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:

_____

Federal Employer Identification # (FEIN):_____

Operating Certificate # (FOR PROVIDERS ONLY): _____

Report(s) being filed electronically (check ALL that apply):

- ☒ Public Goods Pool
- ☐ 1% Statewide Assessment **(for hospitals only)**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _____

Name (Please Print) _____

Title _____

Phone Number _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

E-mail Address _____

Date _____

Note: All fields on this form are required to be accurately completed in order for your request to be processed.

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757