Arizona Foundation for Medical Care

Agreement for Services Abstract

Please Note: An AFMC contract will be drawn up utilizing the information provided on this form. Please ensure that the form is filled out completely and accurately. Please direct any questions to Marketing & Network Management at 800-624-4277.

Fax return to: Marketing & Network Management 602-417-2871 or e-mail to accountmanagement@azfmc.com

PLAN ADMINISTRATOR INFORMATION

Proposed Effective Date: ____________ Company Name (include dbas): ____________

Address: ____________ City/State/Zip Code: ____________

Local phone: ____________ 800 phone: ____________ Fax: ____________

Name and title of authorized signer: ____________

Name and title of contract negotiator: ____________

Contract negotiator phone: ____________ Fax: ____________ E-mail: ____________

Implementation contact: ____________

Address: ____________ City: ____________ State: ____________ Zip Code: ____________

Phone: ____________ Fax: ____________ E-mail: ____________

The following items must accompany this Agreement for Services Abstract:

- New Business Transmittal Advisory
- ID Card Draft (all ID cards must be approved by AFMC prior to effective date and prior to dispersing to employer group/individual
- Contact list

Check all that apply:

Entity: ☐ Carrier ☐ Employer ☐ TPA

Funding arrangement: ☐ Fully Insured ☐ Self-funded ☐ Other

AFMC Plans: ☐ PPO ☐ POS ☐ Chiropractic *

*****Chiropractic network is in addition to the PPO, and POS Network Plans and is an additional fee.

MEDICAL MANAGEMENT

When you utilize AFMC's Utilization Management program - Continuous Hospital Outpatient and Individual case Evaluation (CHOICE) - you are afforded the flexibility to customize the program to suit the needs of your organization. CHOICE features:

- Certification of all emergency and elective inpatient admissions;
- Certification of all outpatient surgical procedures performed in a hospital or outpatient ambulatory surgical center;
- Certification of all home care services and Durable Medical Equipment (DME);
- Certification of all outpatient therapy services.
- Certification for outpatient psychiatric services (This service is subject to a separate charge).

Please indicate the services you would like AFMC to provide: ☐ Utilization Management***** ☐ Case Management
Should you wish to modify the services listed above, please list on a separate page and submit with this form.

*****If your organization chooses not to utilize AFMC's Medical Management program, is the company you are using URAC accredited in Health Utilization Management?

☐ Yes - Please attach a copy of their URAC certification. ☐ No - Please fill out the Utilization Review Questionnaire.

AFMC also offers the following programs at an additional charge. Please indicate the medical management programs you would like by checking the following boxes:

☐ Disease Management ☐ Maternity Management ☐ Wellness Program ☐ 24 Hour Nurse Line ☐ Web Portal ☐ 24/7 Consult a Doc

In order for AFMC to set-up the services selected above, please provide the current Utilization Management company's information:

Company Name: ____________ Contact Name: ____________

Address: ____________ City/State/Zip Code: ____________

Phone: ____________ Fax: ____________ E-mail: ____________

Please provide the current Case Management company's contact information:

Company Name: ____________ Contact Name: ____________

Address: ____________ City/State/Zip Code: ____________

Phone: ____________ Fax: ____________ E-mail: ____________

PAYOR CONTACTS

ACCESS FEE BILLING

Company Name: ______________________ Contact Name: ______________________

Address: ______________________ City/State/Zip Code: ______________________

Phone: ______________ Fax: ______________ E-mail: ______________

ENROLLMENT

Company Name: ______________________ Contact Name: ______________________

Address: ______________________ City/State/Zip Code: ______________________

Phone: ______________ Fax: ______________ E-mail: ______________

Full Enrollment Files Frequency Submission: ☐ Monthly ☐ Bi-monthly ☐ Bi-weekly ☐ Weekly

Note: AFMC requires full enrollment files to be submitted, at a minimum, monthly.

CLAIM ISSUES

Company Name: ______________________ Contact Name: ______________________

Address: ______________________ City/State/Zip Code: ______________________

Phone: ______________ Fax: ______________ E-mail: ______________

PROVIDER UPDATES

Company Name: ______________________ Contact Name: ______________________

Address: ______________________ City/State/Zip Code: ______________________

Phone: ______________ Fax: ______________ E-mail: ______________

Provider updates available at www.azfmc.com (http://www.azfmc.com/index/payor/page/updates).

Please select preferred format: ☐ Full Files ☐ ACDs (Adds, Changes & Terms)

REPORTING (who should receive reports)

Company Name: ______________________ Contact Name: ______________________

Address: ______________________ City/State/Zip Code: ______________________

Phone: ______________ Fax: ______________ E-mail: ______________

Savings Reports

Frequency of reports: ☐ Quarterly ☐ Quarterly YTD ☐ Yearly

Method: ☐ E-mail ☐ Web site

Reports run by: ☐ Administrator Totals Only ☐ Group Totals Only ☐ Administrator & Group (available only to Administrators)

Turn-around-time (TAT) Reports

Frequency of reports: ☐ Quarterly ☐ Quarterly YTD ☐ Yearly

Method: ☐ E-mail ☐ Web site

Reports run by: ☐ Administrator Totals Only ☐ Group Totals Only ☐ Administrator & Group (available only to Administrators)

EDI CONNECTION

Company Name: ______________________ Contact Name: ______________________

Address: ______________________ City/State/Zip Code: ______________________

Phone: ______________ Fax: ______________ E-mail: ______________