Implementation Questionnaire

Please complete the following information:

Client Information			
Business Name (Contract Holder):	Business Type:		
Address:	City:	State:	Zip:
Alternate Address (i.e. PO Box)			
Contact Name:	Title:		
Email:	Phone:	Fax:	
Effective Date Requested:			
Claims Information			
TPA Processing Claims (if different):			
Mailing Address (on ID card):	City:	State:	Zip:
Customer Service Phone:	Claims Fax:		
EDI Payor ID No.:	Clearinghouse:		

1. Will you use a claim vendor? ☐Yes ☐No
   a. If yes, please provide vendor contact information:_____
   _____
2. Would you like to receive IPN provider data weekly? ☐Yes ☐No
   a. If yes, please provide recipient(s) contact information:_____
   _____
3. Would you like to receive IPN full files monthly? ☐Yes ☐No
   a. If yes, please provide recipient(s) contact information:_____
   _____
4. Additional notes:_____
   _____

Please complete the following information for each employer group:

Employer Group Information		
Group Name:	Effective Date:	
Group No.:	☐Self-Funded	☐Fully Insured
Employee Location(s):	Total Employee Count:	
Broker Name/Company:		

Employer Group Information		
Group Name:	Effective Date:	
Group No.:	☐Self-Funded	☐Fully Insured
Employee Location(s):	Total Employee Count:	
Broker Name/Company:		