New Jersey Benefits Administrator Guide

Welcome

Enrollment

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Welcome 1

Enrollment 2

Billing 11

Continuation of Coverage 13

Accessing Forms 19

Contacting AmeriHealth 21

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Welcome
- Overview
- NJ SEH Program
- ID Cards

Enrollment

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Welcome

Dear Benefits Administrator:

Thank you for selecting AmeriHealth for your organization's health plan. AmeriHealth is a customer driven organization that strives to understand and exceed our customer's expectations. We value our relationship with you, and we are committed to giving you and your employees the best possible service.

As the Group Administrator of your AmeriHealth plan, you have the important job of understanding your program and assisting your employees with their questions and concerns. We have prepared this Benefits Administrator Guide to help you manage the day to day administration of your organization's AmeriHealth benefit program.

Using This Guide / Accessing Forms

The Guide describes AmeriHealth processes and procedures, such as enrollment procedures, billing and coordination with Medicare, and even includes sample forms for your use.

To access the forms, using Adobe Acrobat Reader, simply click on any of the underlined form names to download that document to your hard drive, or go to the ***Accessing Forms*** page of this Guide.

Adobe Acrobat Reader is required to view, navigate and print the downloadable forms and guide. Acrobat Reader is freely available on the Adobe website, www.adobe.com.

The State of NJ Small Employer Health Program (SEH)

The State of New Jersey Small Employer Health Benefits Program (SEH) establishes standard benefit plans for small groups for all New Jersey carriers. In addition to the standard SEH plans, optional riders that modify the standard SEH plans and offer a variety of benefit options are also available from AmeriHealth. The SEH Board oversees compliance of carriers and maintains regulatory jurisdiction over products sold to small groups.

This Guide currently contains general information applicable to all plans (including SEH plans) such as billing information and important phone numbers. However, a section of this guide containing additional information specific to SEH plans will be available soon. If you are the Benefits Administrator for a company that has an SEH plan, please contact Member Services, or your Broker or AmeriHealth Account Executive with any enrollment or claims questions.

ID Cards / Member Handbook

Each employee selecting an AmeriHealth plan will receive benefit information and AmeriHealth identification card(s). The third copy of the member's Enrollment/Change Form may be used as a Temporary ID Card until their permanent card is received.

Please take some time to review the material in this Guide. If you require additional information or if you have any questions about your AmeriHealth coverage, please contact your Broker or AmeriHealth Account Executive.

Thank you for choosing AmeriHealth!

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Open Enrollments

Open enrollments are held at least once a year. During the open enrollment period, any eligible employee of the group may enroll in AmeriHealth plan(s) you've selected.

The effective date of coverage is listed on the face sheet of your Group Master Contract, or may be confirmed by your Broker or Account Executive.

Each newly eligible person who enrolls during the open enrollment must complete an Enrollment/Change Form. Employees who are already enrolled in AmeriHealth who wish to remain a member (re-enroll) do not have to complete a new Enrollment/ Change Form during the group's open enrollment period.

Your Broker or Account Executive will assist you in planning and determining the appropriate access for your group's open enrollment (employee meetings, mailing brochures to each employee's home, payroll announcement, etc.). However, employers who routinely encourage mandatory attendance at open enrollment meetings experience fewer difficulties and higher employee satisfaction with their choice of health plans.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment Procedures

Each new subscriber to AmeriHealth, whether joining as a new hire or through the open enrollment, must complete an Enrollment/Change Form. ALL information must be provided to avoid processing delays.

Timing of Enrollment. You may enroll new employees (new hires) and their dependents within 30 days of becoming eligible for health benefits. Your company establishes the eligibility date for health care benefits for new hires for your group.

For Large Groups (51+), if employees are not enrolled within 30 days, they cannot enroll until the new open enrollment period, which is generally a year later.

For Small Groups (2-50), employees may enroll at any time, subject to their employer's waiting period, if any.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Enrollment Forms

All HMO, POS and PPO members use the AmeriHealth Enrollment/Change Form. Be sure your employees carefully read the instructions for completing this form as specific information is required of HMO and POS members, as well as members of SEH groups.

Any time you add a new member or submit a change, you will submit both the Enrollment/Change Form and an Enrollment Report. The Enrollment/Change Form records the change for each individual member, while the Enrollment Report summarizes all the changes being submitted at one time. Both forms need to be completed each time a change is made, even if only one change is being submitted. To access the forms, using Adobe Acrobat Reader, simply click on any of the underlined form names to download that document to your hard drive, or go to the ***Accessing Forms*** page of this Guide.

Note: If you are using forms that you printed from this Guide, you will need to make two extra copies of the **completed** Enrollment/Change Form. The completed original should be forwarded to AmeriHealth. You should retain one copy for your records, the remaining copy is for the employee to use as a Temporary ID Card until their permanent card is received.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Adding/Changing Information

To Add A New Member Using The Enrollment/Change Form: The employee must complete all questions in sections 1, 2, 3, and 3B (if the member is selecting an HMO or POS plan).

Sections 4, 4A, 4B and 4C must be completed if the employee's dependents will also be covered. Please note that for an HMO or POS plan, each dependent must select a primary care physician in section 4A.

The member must also complete sections 5A, 5B and 5C, then sign and date all copies of the form.

As the group administrator, it is your responsibility to complete section 3A. If your organization has more than one group number be sure to indicate the correct group number on each Enrollment/Change Form.

To Change Information For An Existing Member Using The Enrollment/Change Form: (Examples: adding or deleting a dependent or changing an address.) The member must complete sections 2 and 3.

Then, complete just the specific section(s) relating to the change on the Enrollment/Change Form, such as dependent information or primary care office information for HMO or POS members. The employee should then sign and date all copies of the form.

As the group administrator, it is your responsibility to complete section 3A. If your organization has more than one group number, be sure to indicate the correct group number on each Enrollment/Change Form.

Any time you change information for an existing member, we'll ask you to send us both the Enrollment/Change Form and an Enrollment Report. The Enrollment/Change Form records the change for each individual member, while the Enrollment Report summarizes all the changes being submitted at one time. Both forms need to be completed each time a change is made, even if only one change is being submitted.

> ***Note:*** If you are using forms that you printed from this Guide, you will need to make two extra copies of the **completed** Enrollment/Change Form. The completed original should be forwarded to AmeriHealth. You should retain one copy for your records, the remaining copy is for the employee to use as a Temporary ID Card until their permanent card is received.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Completing The Enrollment Report

The Enrollment Report summarizes all the additions and changes submitted at one time.

A completed Enrollment Report must be included anytime you request a change, even if you are submitting only one Enrollment/Change Form.
The Enrollment Report must be filled out in its entirety, including: the group number, group name, current effective date, address and phone number, so we can contact you if there are any questions about the report.

Each numbered line should reflect the information on one of the enrollment forms included in the submission. Be sure to include the member's identification number, the effective date of the change, and indicate whether the change is an addition, a change, or a removal. If the change is a removal, be sure to include the removal code number, which can be found on the bottom of the form, and include the terminated member's address in the "Remarks" section. Once you've completed all the necessary lines, simply total the number of transactions by type, then enter the grand total of all transactions in the designated box.

Keep copies for your records, and mail the original documents to the address at the top of the form.

Because insurance bills are prepared in advance of the coverage date, changes may not appear on your bill for one or two monthly billing cycles. To avoid any potential payment problems, ***you should always pay the billed amount***. Any credits or additional premium due will "catch up" on subsequent bills.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Dependent Verifications

If a dependent is a full-time student over the dependent age limit specified in your contract, the Student Verification Form must be completed and attached to the Enrollment/Change Form.

If the dependent has a disability and is dependent on the member for more than half of his or her support, the Application to Continue Coverage For Handicapped Dependent Child must be completed and attached to the Enrollment/Change Form.

Dependent verification forms are also mailed out periodically to determine whether an overage dependent remains eligible for coverage. These forms are sent directly to members with dependents over the contract termination age. When your employees receive these forms, they must be completed and returned within 30 days, otherwise the dependent will be automatically removed from the contract.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID’s
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Temporary ID's

It is important that you retain a copy of the completed Enrollment/Change Form for your records and provide the employee with a copy for use as their Temporary ID. This copy of the enrollment form is the employee's Temporary ID Card. If any enrolled member requires care before they receive their Permanent ID Card, they simply present this form at their physician's office to receive all the benefits to which they are entitled.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Special Information For HMO And POS Members

Each member of the family must select a primary care physician from AmeriHealth's physician network. Female members do not have to pre-select an AmeriHealth OB/GYN.

Participating physician's names and Primary Care Office Code Numbers are listed in the AmeriHealth Directory, and are also available by calling the Health Resource Center physician referral line at 1-800-275-2583, or online under Providers at www.amerihealth.com.

If an HMO or POS member does not select a primary care physician, or selects a physician with a closed practice or one who is no longer participating with AmeriHealth, the member's Identification Card cannot be issued. The member will receive notification to select another primary care physician.

Members may change their primary care physician up to two times per calendar year. Members wishing to change their primary care physician may contact the Member Services Department at 1-800-877-9829 to make their selection.

Welcome

Enrollment
- Open Enrollments
- Enrollment Procedures
- Enrollment Forms
- Adding/Changing Information
- Completing the Enrollment Report
- Dependent Verification
- Temporary ID's
- HMO/POS Notes
- Prior Carrier Deductible Credit

Billing

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Enrollment

Prior Carrier Deductible Credit

If under your previous plan you incurred expenses that were credited toward your annual deductible in the calendar year or benefit period in which your group became effective, you can receive deductible credit toward your new policy with AmeriHealth.

Eligibility: If you are a new AmeriHealth member and incurred expenses related to a deductible under your previous carrier, you are eligible. In order for you to take advantage of this benefit you must provide AmeriHealth with the required documentation, as soon as possible or no longer than 90 days after your enrollment date to receive full credit.

The Application Process: Submit a copy of your most recent Explanation of Benefits (EOB) from your prior insurance carrier, complete the Prior Carrier Deductible Credit Form, attach your EOB(s) and submit to AmeriHealth at the address below.
Please remember you have only 90 days from your enrollment date to submit your EOB and Prior Carrier Deductible Credit Form to receive full credit. After 90 days you may forfeit some or all of your credit. Since annual deductibles apply to each family member, we will need information specific to each of your dependents who will be covered. For example, a husband must submit an EOB indicating his credit to be applied and a wife will need to provide an additional EOB indicating her credit to be applied.

You will receive a letter from AmeriHealth verifying that we received your request and documentation to receive Prior Carrier Deductible Credit (PCDC) Form. The letter will also indicate each family member's individual amount that will be credited toward your new deductible.

Prior Carrier Deductible Credit Checklist

- Prior Carrier Deductible Credit Form completed
- Prior Carrier EOB
  (please retain a copy for your records)
- EOB's indicating credit to be applied for each family member Mail both the Prior Carrier Deductible Credit Form and EOB(s) to:

  AmeriHealth
  Prior Carrier Deductible Credit
  PO Box 7450
  Philadelphia, PA 19101-9102

Welcome

Enrollment

Billing
- Overview
- Notes

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Billing

Overview

Itemized invoices are sent on a monthly basis, approximately 15 days in advance of the month of coverage. Invoices for a given month of coverage are based on the actual group enrollment for the prior month. This enables billing and payment to occur in advance of the covered month.

To avoid payment problems, it is important to always pay the amount BILLED, even though it may not reflect your most recent additions and terminations.

DO NOT write membership or plan changes on your invoice. These changes will not be made. The proper way to report enrollment changes is to use the Enrollment/ Change Form and the Enrollment Report.

Enrollment changes made via the Enrollment Report will generally be processed within three (3) days of receipt. Enrollment changes processed by the night of billing will appear on the bill.

The Enrollment Report should be mailed to the Enrollment Department along with the Enrollment/Change Forms indicating the desired action. This could include adding dependents to a contract (due to birth, adoption or marriage), or making any changes to an individual's coverage i.e. marriage, divorce, legal separation, death of a spouse or dependent, loss of eligibility for coverage or moving out of the AmeriHealth service area.

Similarly, if you are terminating an individual's coverage, or deleting dependents, use the AmeriHealth Enrollment Report Form, but ***continue to remit the billed amount. Do not delete billed premium amounts or add the additional premium due in your remittance***. The next invoice will reflect the person(s) retroactively added or deleted and any corresponding change to your premium balance. ***Adjustments made will appear in the "Retroactive Adjustments" section of the invoice.***

Simply detach the remittance coupon from the bottom of the first page of your invoice and return it with your payment to the address indicated on your bill. ***If you are including multiple payments in one envelope, please be sure to indicate on each coupon the amount to be applied to each account/group.*** The sum of all coupons must equal the full amount of the check you are remitting. This will ensure that your payment is credited to the proper account.

Welcome

Enrollment

Billing
- Overview
- Notes

Continuation of Coverage

Accessing Forms

Contacting AmeriHealth

Billing

Notes on Coverage and Billing Cycle for HMO and POS Groups

If your groups' effective date is the 1st of the month:

- If members are added from the 1st to the 15th day of your billing cycle, **you will be billed for that month.**
- If members are added from the 16th to the last day of your billing cycle, **you will not be billed for that month.**
- If members are dropped from the 1st to the 15th day of your billing cycle, **you will not be billed for coverage from that month.**
- If members are dropped from the 16th to the last day of your billing cycle, **you will be billed for coverage for that month.**

If your groups' effective date is the 15th of the month:

- If members are added from the 1st to the 14th day of your billing cycle, **you will not be billed for that month.**
- If members are added from the 15th to the last day of your billing cycle, **you will be billed for that month.**
- If members are dropped from the 1st to the 14th day of your billing cycle, **you will be billed for coverage from that month.**
- If members are dropped from the 15th to the last day of your billing cycle, **you will not be billed for coverage for that month.**

For assistance with billing reconciliations, please call the phone number that appears on your bill.

Welcome

Enrollment

Billing

Continuation of Coverage
- Termination or Cancellation of Membership
- Continuation of Coverage
- COBRA: Overview of the Law
- Medicare as Secondary Payer

Accessing Forms

Contacting AmeriHealth

Continuation of Coverage

Termination Or Cancellation Of Membership

Termination of membership occurs when an employee terminates his or her employment and loses group eligibility in such instances.

AmeriHealth will accept COBRA (required by law for groups employing 20 or more) or an extension of benefits through conversion coverage.

Small employers with between two and 19 employees must offer employees the option to continue their group health coverage, at the expense of the employee, when an employee is terminated for reasons other than cause, when he or she goes to part-time status, or if an employee ends employment. An employee on continuation would pay his or her premium to you, which you would remit as part of your regular premium payment.

Cancellation occurs when a member who remains eligible for group health benefits chooses to cancel AmeriHealth membership. Conversion is not offered in this situation.

Welcome

Enrollment

Billing

Continuation of Coverage
- Termination or Cancellation of Membership
- Continuation of Coverage
- COBRA: Overview of the Law
- Medicare as Secondary Payer

Accessing Forms

Contacting AmeriHealth

Continuation of Coverage

Continuation of Coverage

Small employers with between two and 19 employees must offer employees the option to continue their group health coverage, at the expense of the employee, when an employee is terminated for reasons other than cause, when he or she goes to part-time status, or if an employee ends employment. An employee on continuation would pay his or her premium to you, which you would remit as part of your regular premium payment.

Employers have a legal obligation to notify their employees of the right to continue coverage at the time of termination or at the time the employee assumes part-time status. An employee has the right to continue coverage for up to 12 months. The decision to continue coverage may be made by the employee only; dependents do not have an independent right to elect continuation, in most instances.

The policy or contract issued to you and the certificate or evidence of coverage issued to the covered employees outlines the procedures that the employer and employee must follow for continuation of coverage. Small employers with 20 or more employees must also offer an option of continuation of coverage under a federal law, commonly referred to as COBRA, which contains provisions which differ from those described above.

The employer must complete an Enrollment Report in order to terminate an employee's coverage. The form must provide all the required information and must be dated and signed by the employer.

The employer is responsible for submitting the Enrollment Report Forms within 60 days of the termination date to AmeriHealth at the address on the form.

Welcome

Enrollment

Billing

Continuation of Coverage
- Termination or Cancellation of Membership
- Continuation of Coverage
- COBRA: Overview of the Law
- Medicare as Secondary Payer

Accessing Forms

Contacting AmeriHealth

Continuation of Coverage

Medicare As Secondary Payer

We hope to simplify a complex subject—when Medicare is the primary payer for Medicare eligible members of your employee group. If your company has 19 or fewer full and part-time employees, Medicare is almost always primary. If your firm is larger, various rules apply to determine whether your group plan is the primary or secondary payer.

The following information provides a summary of the Medicare Secondary Payer (MSP) requirements. This information may help you to correctly target benefits for your Medicare-eligible participants and to avoid potentially costly penalties and litigation. You should, of course, also refer to the actual laws and regulations with the assistance of your own legal counsel.

Information Regarding The Medicare as Secondary Payer Statute

Employers, group health plans ("GHPs") and entities that sponsor or contribute to GHPs, as well as insurers, have certain obligations under the Medicare Secondary Payer ("MSP") provisions of the Social Security Act, commonly known as the "MSP statute." As an employer or administrator of a GHP you need to know the requirements of the statute, for among other reasons, to avoid potentially costly penalties and litigation. This guide is designed to provide you with a general overview regarding operation of the MSP statute and the enrollment and membership information system that is being developed to obtain information necessary to detect instances in which the MSP statute applies.

I. The MSP Law

A Coordination of Benefits Approach: During the first 15 years of the Medicare program, Medicare was the primary payer of all services provided to Medicare beneficiaries, with the sole exception of services covered under a workers' compensation policy or program. As a result, where a Medicare beneficiary had dual health care coverage, Medicare paid first, and the employer, GHP or insurer paid all or a portion of the remainder of the bill for the health care item or service at issue, depending on the terms of the relevant plan or contract. In an effort to save scarce Medicare resources, Congress enacted a series of amendments to the Social Security Act, beginning in 1981, which made GHPs responsible in certain instances for making primary payment in connection with medical items or services provided to specific Medicare beneficiaries with dual health care coverage.

1. The MSP provisions are set forth at 42 U.S.C. ß1395y(b). The regulations the Health Care Financing Administration has issued implementing the statute are located at 42 C.F.R. Part 411. It is important that you and your counsel review the statute and regulations periodically to ensure compliance with your statutory obligations. This content is provided for informational purposes, and is not offered or intended as legal advice.

2. In this section, the term "employer" includes a plan sponsor or entity that contributes to a GHP.

Welcome

Enrollment

Billing

Continuation of Coverage
- Termination or Cancellation of Membership
- Continuation of Coverage
- COBRA: Overview of the Law
- Medicare as Secondary Payer

Accessing Forms

Contacting AmeriHealth

The MSP statute is essentially a coordination of benefits statute. It requires, in discrete instances, that a GHP make primary payment where dual coverage exists for a particular health care item or service. Employers are constrained in the benefits they can offer employees and other individuals covered under the plan. The statute specifically prohibits employers and GHPs from differentiating between benefits offered to certain Medicare beneficiaries and their counterparts not enrolled in Medicare. The anti-discrimination provisions of the statute are explained more fully below.

Scope of the Statute: The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and GHP coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

1. GHPs that cover participants with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

2. In the case of a covered participant or his or her covered spouse age 65 or over, a GHP of an employer that employs 20 or more employees, if that participant has "current employment status." If the GHP is a multi-employer or multiple employer plan the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

3. In the case of a covered participant or his or her covered family member who is disabled and under age 65, GHPs of employers that employ 100 or more employees, if participant has "current employment status." If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees. (There is no small employer exception under the statute).

In determining whether the size threshold has been met in any given case, the statute and regulations must be consulted.

Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage is provided under the GHP based on "current employment status." Thus, generally the age-based and disability-based MSP provisions apply when the GHP participant (not necessarily the covered person with Medicare) has "current employment status." (By contrast, the MSP provisions relating to individuals who have ESRD apply regardless of whether the beneficiary has GHP coverage as a result of "current employment status" and regardless of the number of employees which an employer employs.) Under HCFA regulations, an individual has "current employment status" if the individual: (1) is "actively working as an employee, [is] the employer...or [is] associated with the employer in a business relationship;" (2) is "not actively working" but is "receiving disability benefits from an employer for up to 6 months;" or (3) is "not actively working" but "retains employment rights in the industry" and other specific requirements are met. For

Welcome

Enrollment

Billing

Continuation of Coverage
- Termination or Cancellation of Membership
- Continuation of Coverage
- COBRA: Overview of the Law
- Medicare as Secondary Payer

Accessing Forms

Contacting AmeriHealth

additional information, we again direct your attention to the statute and regulations.

The Non-discrimination Provisions - Age and Disability: The MSP statute prohibits GHPs from "take[ing] into account" that an individual covered by virtue of "current employment status" is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to Medicare beneficiaries the same benefits, under the same conditions, that they furnish to employees and spouses not entitled to Medicare. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that "carves out" Medicare coverage (commonly known as a "carve-out" policy), or which supplements the available Medicare coverage (commonly known as "Medicare supplemental" or "Medigap" policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, "Medigap" and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on "current employment status."

ESRD: The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and ends 30 months later. During this period, the GHP generally must pay primary for all covered health care items or services, while Medicare serves as the secondary payer. **GHPs are prohibited from offering secondary (i.e., "carve-out") and "Medigap" coverage in this context.** After the coordination period has expired, however, the GHP is free to offer "carve-out" and "Medigap" coverage to ESRD Medicare beneficiaries, but may not otherwise differentiate between the benefits provided to these individuals and all others on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. (Important Note: Special rules apply to persons eligible for or entitled to Medicare based on ESRD and one or more other reasons.)

Special rules apply regarding retired individuals and members of their families who receive Medicare benefits on the basis of age or disability immediately before the onset of ESRD. Where immediately prior to contracting the disease, the GHP was lawfully providing only "Medigap" coverage, or was otherwise a secondary payer for that individual, the GHP may continue to offer such coverage and is not required to pay primary during the 30 month coordination period.

Employer Obligations: **It is your obligation to ensure that beneficiaries who are covered by the MSP statute are not improperly enrolled in "carve-out" or "Medigap" coverage under your Plan. If an individual is improperly enrolled in a supplemental or secondary policy or contract when the individual should be enrolled in a plan that makes the GHP the primary payer, it is Medicare's position that Medicare pays secondary and the plan is required to pay primary regardless of contrary language contained in the plan or contract.**
These individuals may choose to purchase and pay for "Medigap" insurance on their own, but neither the employer nor the GHP may sponsor, contribute to, or finance

Welcome

Enrollment

Billing

Continuation of Coverage
- Termination or Cancellation of Membership
- Continuation of Coverage
- COBRA: Overview of the Law
- Medicare as Secondary Payer

Accessing Forms

Contacting AmeriHealth

such coverage.

Prohibition of Financial or Other Incentives Not to Enroll in a GHP: An employee or family member of an employee who is entitled to Medicare is free to refuse the health plan offered by an employer or GHP, in which case Medicare will be the primary payer. It is unlawful, however, for an employer to offer any financial or other incentive for a Medicare beneficiary not to enroll, or to terminate enrollment, in a GHP which would be primary to Medicare if the individual enrolled in the GHP. Any entity violating this prohibition is subject to a civil monetary penalty under the MSP statute of up to $5,000 for each violation.

Other consequences of Non-compliance: Non-compliance with the statute can result in serious consequences. Thus, a significant excise tax in the amount of 25 percent of the employer's or employee organization's GHP expenses for the relevant year may be assessed under the Internal Revenue Code against a private employer or employee organization contributing to a "non-conforming" group health plan. Under HCFA Regulations, a non-conforming group health plan is a plan that, for example: (1) improperly takes into account that an individual is entitled to Medicare; (2) fails to provide the same benefits under the same conditions to employees (and spouses) age 65 or over, as it provides to younger employees and spouses; (3) improperly differentiates between individuals with ESRD and others; or (4) fails to refund to HCFA conditional Medicare payments mistakenly made by the agency. It is Medicare's position that, in addition to the possible imposition of an excise tax, failure to reimburse HCFA for mistaken primary payments may result in ultimate liability double the amount at issue. The law also establishes a private cause of action to collect double damages from any GHP that fails to make primary payments in accordance with the MSP provisions.

Amendments to the MSP Statute and Regulations: The MSP statute and regulations are frequently amended. As a result, it is important that you and your counsel continue to monitor changes in the law and assess the impact of such changes on your company. While we can assist you by providing general information about the statute, it is ultimately your responsibility to ensure your company's compliance with MSP statute.

Welcome

Enrollment

Billing

Continuation of Coverage

Accessing Forms
- Enrollment Forms
- Claims Forms

Contacting AmeriHealth

Accessing Forms

Enrollment Forms

The Guide describes AmeriHealth processes and procedures, such as AmeriHealth's eligibility policy, enrollment procedures, premium invoicing and coordination with Medicare, and includes forms for your use. To access the forms, simply click on any of the underlined forms below.

For detailed explanation and instructions on the use of these forms, please refer to the Enrollment section of this Guide.

Enrollment/Change Form

Used to add new members or change member information for any health plan. Three copies required and should be used in the following manner:

1. AmeriHealth copy
2. Employer's records
3. Temporary ID card for new members

(Form number: AH752-EN)

Enrollment Report: Additions, Changes and/or Removals

Used to summarize the information on Enrollment/Change Forms. Also used to remove members from coverage (no Enrollment/Change Form required.)

(Form number: 19425)

Application to Continue Coverage for Handicapped Dependent Child

Used to certify that a dependent is disabled, is unmarried, and depends on the member for more than half of his or her support.

(Form number: none)

Dependent Verification Form: Student

Used to certify that an "overage" dependent is a full-time student. Required at enrollment, distributed as well by AmeriHealth annually for member update and response.

(Form number: 01417)

Prior Carrier Deductible Credit

Used to claim credit for expenses incurred under the member's previous plan that may be applied toward the member's current AmeriHealth plan deductible.

(Form number: 359C)

Note: Members have only 90 days after their AmeriHealth enrollment date to receive full credit.

Welcome

Enrollment

Billing

Continuation of Coverage

Accessing Forms
- Enrollment Forms
- Claims Forms

Contacting AmeriHealth

Accessing Forms

Claims Forms

For detailed explanation and instructions on the use of these forms, please refer to the Claims section of this Guide.

AmeriHealth Claim Form

Used by CMM members to file claims, and by PPO members to file claims for services by providers who do not participate with AmeriHealth.

(Form number: 19325)

Point of Service Claim Form

Used by Point of Service members to file claims under the self-referred part of their health plan.

(Form number: 19328)

Contacting AmeriHealth

Important Phone Numbers

Communication is a priority for us here at AmeriHealth. If you have any questions regarding the administration of your group insurance plan, please call your AmeriHealth Service Team at the the appropriate number shown below.

Member Services	
HMO/POS	800-877-9829
PPO/CMM	800-422-2457
AmeriHealth65	800-645-3965
Employer Services	
HMO/POS	800-893-7827
PPO/CMM	800-893-7827
Accounts Receivable	
HMO/POS	888-854-7000
PPO/CMM	888-854-7000
Pre-Certification	**800-227-3116**
HMO/POS/ AmeriHealth65	Prompt 1
PPO/CMM	Prompt 2
Baby FootSteps	**800-598-BABY**
Health Resource Center	**800-275-2583**
Network Physician Referral	Prompt 3
Healthy Lifestyles	Prompt 4
Megellen (Mental Health)	**800-688-1911**
Caremark Member Services	**877-252-3485**

AmeriHealth Enrollment
P.O. Box 42555
Philadelphia, PA 19101-2555

Thank you for choosing AmeriHealth!

AmeriHealth

ENROLLMENT/CHANGE FORM

For all plans, including New Jersey Small Group Employer Benefits Program

Send to:
AmeriHealth Enrollment
P.O. Box 42555
Philadelphia, PA 19101-2555

1 Plan (please specify Fast Track or Standard)

1A Standard Plans (Indicate co-pay amount and deductible)

HMO	POS	PPO	CMM	Rx	Vision	Dental

1B Fast Track (Circle co-pay)

HMO		POS		PPO	
$10	$20	$10	$20	$10	$20

2 Subscriber/Member Enrollment or Change - Employee Must Complete in Full

❑ **New Application**
- ❑ New Hire
- ❑ Open Enrollment
- ❑ Life Event Change

Complete all information and sign form.

❑ **Information Change**
Provide your Identification Number below and indicate the change(s) you are making. Complete appropriate section(s) and sign at bottom of form.
I.D. # _____

❑ **Change**
- ❑ Address
- ❑ Last Name
- ❑ Primary Care Office
- ❑ Rehire
- ❑ DentalOffice

❑ **Dependent Membership Change**
- ❑ Add Dependent
  If adding spouse, indicate marriage date ___/___/___
- ❑ Delete Dependent

❑ **Other Change**
- ❑ COBRA ❑ Conversion
- ❑ 18 mos. eff. date: ___/___/___
- ❑ 29 mos. eff. date: ___/___/___
- ❑ 36 mos. eff. date: ___/___/___

❑ **Terminate Contract**
- ❑ Terminated Employment
- ❑ Full-time to Part-time
- ❑ Deceased, date: ___/___/___
- ❑ Open Enrollment
- ❑ Other:_____

3 Subscriber Information

NOTE: Please complete this section in its entirety, whether you are a new applicant or are making a change to an existing contract.

Social Security Number	Last Name	First Name	Middle Initial	Sex ❑ M ❑ F	Date of Birth month/day/year / /

Street Address	City	State	Zip Code

Telephone Number (include area code)	Employment Status	Marital Status	Previous Health Insurance
Home: ( ) — Work: ( ) —	❑ Active ❑ COBRA ❑ Retiree	❑ Single ❑ Divorced ❑ Separated ❑ Married ❑ Widowed	

3A Group/Employer Information

Your **Group Administrator** must complete this section. This form **cannot be processed** without this information.

❑ **Check if National Account**

Group/Account Number	Group Name (Full Legal Name of Company)

Group Address

Employer Signature and Date

3B Complete this section for HMO or POS Only

Primary Care Office Name	If Current Physician Check This Box ❑	Primary Care Office Code Number	Date of Hire ___/___/___	Date Coverage/Change is Effective ___/___/___
Primary Dental Office Name	If Current Dentist Check This Box ❑	Primary Dental Office Code Number	Payroll/Work Location	Location Name/Phone #

4 Dependent Information - Please provide all information for each person to be covered.

4A For HMO/POS Only

4B Verifications

Full Name Last Name	First Name	Middle Initial	Sex	Date of Birth Month/day	Social Security Number	Primary Care Office Name	Primary Care Office Number	If current physician, check box at right.	Overage Student? Please attach verification.	Disabled? Please attach verification.
Spouse			❑ M ❑ F					❑		
Child			❑ M ❑ F					❑	❑ Yes ❑ No	❑ Yes ❑ No
Child			❑ M ❑ F					❑	❑ Yes ❑ No	❑ Yes ❑ No
Child			❑ M ❑ F					❑	❑ Yes ❑ No	❑ Yes ❑ No

4C

If you have listed any dependents in the Dependent Information Section, **you must answer the questions below.**

Do any of the dependents listed in this section live at another address?
❑ Yes ❑ No

If yes, who and at what address? Explain the circumstances:

If any dependent's last name is different from yours, explain the circumstances:

5 Other Insurance Information

To be sure that you receive all the benefits to which you are entitled, you must complete the following:

5A Is your spouse employed? ❑ Yes ❑ No
If yes, please give name, address, and phone number of spouse's employer _____

5B Are you or any of your dependents currently receiving Medicare benefits
❑ Yes ❑ No If yes, please give name of recipient.

	PART A	EFFECTIVE DATE	PART B	EFFECTIVE DATE	MEDICARE CLAIM NUMBER
SELF	❑ Yes ❑ No	- -	❑ Yes ❑ No	- -	
SPOUSE	❑ Yes ❑ No	- -	❑ Yes ❑ No	- -	
CHILD	❑ Yes ❑ No	- -	❑ Yes ❑ No	- -	

5C When you become effective with our policy, will any persons listed on this enrollment form be covered by any other health insurance policy?
❑ Yes ❑ No
If yes, please give name and policy no. of insurance carrier and type of benefits.
Ins. Co. Name _____
Policy Number _____
Policy Holder _____
Type of benefits:
❑ Health ❑ Prescription ❑ Dental ❑ Vision

Who is covered by this policy? List names of those covered.
(1) _____
(2) _____
(3) _____
(4) _____

Important: Please read the back of this form, then sign below.

_____ Signature of Employee

_____ Date Signed

Copy 1: AmeriHealth **Copy 2: Employer** **Copy 3: Temporary ID**

COMPLETE THIS SECTION IF APPLYING FOR COVERAGE UNDER THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM ONLY.

Occupation: _____ Title: _____ Date of Employment: _____ Hours Worked Per Week: _____ Are you actively at work? ____ Yes ____ No
If "No", explain: _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Health Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Persons to be covered: ❑ Employee Only ❑ Employee & Child(ren) ❑ Employee & Spouse ❑ Employee, Spouse & Child(ren)

Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury? ____ Auto ____ Medical

Are you replacing existing coverage? ____ Yes ____ No If "Yes", give the name and policy number of the replaced carrier, the effective and termination dates, and the name(s) of the persons covered by the policy_____
_____

Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? ____ Yes ____ No If "Yes", attach the Certificate of Group Health Plan Coverage. Please note that if you do not provide the Certificate of Group Health Plan Coverage, you and any dependents to be covered, may be required to satisfy the preexisting conditions limitation, if applicable.

DECLARATION AUTHORIZATION AND CONDITIONS OF ACCEPTANCE FOR THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

I hereby enroll for the group coverage to which I am or may be entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent that to the best of my knowledge and belief, the statements and answers given above are true and complete. I understand that the information shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a) the coverage applied for will not take effect unless:
- after review of this Enrollment Form, AmeriHealth accepts it;
- the first premium has been paid to AmeriHealth; and
- I am either actively at work for full pay on a full-time basis on the date coverage is to take effect, or subject to applicable regulations, I qualify under a waiver of the active work requirement

b) no person, except an officer of AmeriHealth has authority to: determine whether certificate/evidence of coverage shall be issued based on this Enrollment Form, waive or modify any of the provisions of the Enrollment Form, or any of the AmeriHealth Requirements; to bind AmeriHealth by any statement or promise pertaining to any certificate/evidence of coverage to be issued on the basis of this Enrollment Form; or accept any information or representation not contained in the written Enrollment Form.

c) the Employer is hereby designated my representative for the purpose of receiving contributions and remitting them to AmeriHealth.
- AmeriHealth does not pay benefits for charges, or provide services or supplies related to a preexisting condition for 180 days, measured from the enrollment date. I understand that a Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date. I also understand that New Jersey Law only permits the application of the preexisting conditions limitation under certain circumstances and that I or my dependents will only be subject to this limitation to the extent permitted by New Jersey Law.

I understand that by signing below when I file a claim, AmeriHealth may pay the health care benefits directly to the provider instead of to me.

I state that I am a resident of New Jersey and I live, reside or work within AmeriHealth's service area. I understand that if I omit or falsify any statement on this enrollment form, AmeriHealth can cancel my coverage as of the original effective date.

Any person who includes any false or misleading information on an application or enrollment form and change form for a health benefits plan is subject to criminal and civil penalties.

Note: A person who was covered under Creditable Coverage has a right to request a certificate from the prior plan or issuer to demonstrate that he or she was covered under Creditable Coverage. If necessary, AmeriHealth will assist the person in obtaining a certificate from the prior plan or issuer.

Conditions of Acceptance

On behalf of myself and the dependents listed on this Enrollment Form, I agree to or with the following:

1. Employee is applying for coverage for the employee, employee's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated and who are chiefly dependent upon the employee or the employee's spouse for support and maintenance or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are enrolled as full-time students at an accredited school.
2. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Contract.
3. The Contract will determine the rights and responsibilities of members and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
4. As a condition to receiving in-network benefits, employee understands and agrees that with the exception of emergency procedures as defined in the Contract all in-network services, in order to be covered by AmeriHealth, must be performed either by a participating primary care physician or by the participating specialist, hospital or other provider as authorized by prior written referral from the participating primary care physician. Out-of-network benefits are covered, as stated in the contract.
5. Employee agrees to make payment directly to health care providers such copayments as are provided in the employer's health benefits plan.
6. Employer understands that this coverage will remain in effect regardless of the continued availability of a particular primary care physician.
7. Employee acknowledges that AmeriHealth's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of AmeriHealth.

Authorization

1. I authorize the sources stated below to give to AmeriHealth, or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for coverage. Such information will pertain to employment, other health coverage, and medical advice, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any carrier; any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which AmeriHealth has taken in reliance on the authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have a right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

I understand that if I choose an HMO Product the provision of services to me and my dependents as Members of AmeriHealth is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initialed at the primary care office or primary dental office (as appropriate) we have selected; and 2) and my dependents authorize any person or organization providing services to furnish AmeriHealth with medical or dental records or other information concerning such services for purposes of AmeriHealth quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all non-referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and AmeriHealth specify.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

AmeriHealth

MAIL TO: AmeriHealth Enrollment
P.O. Box 42555
Philadelphia, PA 19101-2555

Enrollment Report: Additions, Changes and/or Removals

Group Number_____ Group Name_____ Effective on_____ billing
Month/Year

Group Address_____ Submitted by_____ Phone no. (_____)_____
City State Zip Code

Name (please print or type)	Identification number	Please leave blank AmeriHealth only	Effective date of this transaction MM DD YY	Additions (1)	Changes (2)	Removals (3)	Removal Code Number *(4)	Remarks Note address for all terminations (include zip code)
1_____								_____
2_____								_____
3_____								_____
4_____								_____
5_____								_____
6_____								_____
7_____								_____
8_____								_____
9_____								_____
10 _____								_____
Totals								

Total number of items you are reporting = ☐

IMPORTANT
Completed Group Application/Change Form must be enclosed with this report.
Follow instructions on reverse side.

***REMOVAL CODES**

1. Change to Aetna US Healthcare
2. Change to BC/BS
3. Change to Commercial HMO.
4. Change to Commercial Insurer.
5. Covered by spouse - Please indicate spouseís I.D. # in remarks column.
6. Transfer from group to group - Please indicate new group number in remarks column.
7. Deceased - If surviving dependents, please indicate in remarks column if dependents should remain in group.

General Instructions

1. To report new members, changes in coverage or terminations, print the names of the members in the space provided. Opposite each name fill in the identification number and the proposed effective date. Indicate (X) in columns 1, 2 or 3, depending on the type of transaction. Indicate Removal Code Number in column 4. Removal Codes are listed on reverse side.

2. Enter the respective totals of additions and removals at the bottom of columns 1 and 3 on each page.

3. Enter the total number of enrollment items reported in the box provided.

4. Forward this report and any application/change forms (for all additions and changes) to:

   Enrollment Department
   AmeriHealth Enrollment
   P.O. Box 42555
   Philadelphia, PA 19103-2555

5. Do not remit payment with this report. You will receive a billing reflecting these changes at a later date.

6. Retain a copy of this report for your records. This will help you verify that requested changes were completed when you receive your bill.

7. If you have any questions concerning this report, billing procedures or enrollment information, please call the telephone number in the upper right corner of your bill.

APPLICATION TO CONTINUE COVERAGE FOR HANDICAPPED DEPENDENT CHILD

Certification of Attending Physician

(must be completed by attending physician)

Note: Any fee for the completion of this form is the responsibility of the member

Physician's Name _____ **Degree/Specialty** _____

Address _____ **Phone** _____

_____

_____

1. **The noted patient is presently under my care** _____ **Yes** _____ **No**
2. **Date Dependent was last treated** _____
3. **Diagnosis and concurrent conditions** _____

   _____

   _____
4. **Has such disability existed continuously since before Dependent attained age 19?** ___ **Yes** ___ **No**
5. **Has Dependent been confined in a hospital as a result of this disability?** _____ **Yes** _____ **No**

   If yes, give name and address of hospital _____

   _____

   Date Admitted _____ **Date Released** _____
6. **Nature of treatment:**

   A. Medication - i.e. dosage, frequency _____

   _____

   B. Care Plan _____

   _____

   C. Compliance with Prescribed Treatment

   _____ **Good** _____ **Fair** _____ **Poor**
7. **Prognosis:**

   Is dependent totally disabled and incapable of self support? _____ **Yes** _____ **No**

   If not totally disabled, is dependent capable of self support? _____ **Yes** _____ **No**

   Do you expect a fundamental or marked change in the dependent's condition in the future?

   _____ **Yes** _____ **No**

   If yes, when will the patient recover sufficiently to be capable of self support?

   _____

   If no, please explain: _____

   _____
8. **Additional Remarks:** _____

   _____

   _____

Signature _____ **Date Signed** _____

APPLICATION TO CONTINUE COVERAGE FOR HANDICAPPED DEPENDENT CHILD

Member Name _____ **Identification No.** _____

Street Address _____ **Employer's Name** _____

City _____**State** _____ **Zip** _____ **Employer's Address** _____

_____

I HEREBY APPLY FOR CONTINUATION OF COVERAGE FOR THE FOLLOWING CHILD UNDER MY SUBSCRIPTION AGREEMENT(S):

Name of Dependent _____ **Birthdate** _____

Relationship to Member _____ **Is Dependent Married?** _____ **Yes** _____ **No**

Is the Dependent:
- **a. Receiving Benefits** _____ **Yes** _____ **No**
- **b. Covered by Medicare** _____ **Yes** _____ **No**
- **c. Receiving Social Security Benefits** _____ **Yes** _____ **No**

If your dependent is presently enrolled under his/her own AmeriHealth Agreement,. give:
Id # _____ **Group Plan** _____ **Location** _____

I hereby certify that the above child is unmarried, is incapable of self-support, is in fact dependent upon me for over half of his or her support and that my child's disability commenced prior to attaining 19 years of age.

I understand and agree as follows: That the requested coverage for the above child shall not become effective unless and until this application is accepted and approved by AmeriHealth and thereafter may be revoked by AmeriHealth if any of the statements made herein are incorrect or if AmeriHealth later determines that the above dependent no longer qualifies for coverage as a handicapped dependent; That this application will become a part of my original application and will be subject to the terms of my subscription agreement(s); and; That acceptance of this application does not confer eligibility upon the above child for Major Medical benefits unless the group agreement describing the Major Medical Program so stipulates.

I further understand and agree that AmeriHealth reserves the right to request additional documentation if required.

Signature _____ **Date Signed** _____

handic.doc

AmeriHealth

STUDENT VERIFICATION FORM

DEL _____ NJ_____
HMO_____ PPO_____

PART I - MEMBER INFORMATION	*Please put responses on this column*
DEPENDENT NAME	
DEPENDENT MEMBER ID	
SUBSCRIBER NAME	
SUBSCRIBER SOCIAL SECURITY NUMBER	

PART II - DEPENDENT RELEASE	
I authorize the named school to release my enrollment status to AMERIHEALTH	
DEPENDENT SIGNATURE	
SIGNATURE DATE	

PART III - STUDENT VERIFICATION	*To be completed by the Registrar*
NAME OF SCHOOL	
CURRENT ENROLLMENT STATUS	
CURRENT TERM	
ATTEMPTED SEMESTER HOURS	
EXPECTED DATE OF COMPLETION	
IF GRADUATED, DATE DEGREE AWARDED	
REGISTRAR SIGNATURE Validate with School Stamp	
SIGNATURE DATE	

SUBSCRIBER'S SIGNATURE	
SIGNATURE DATE	
We verify that the above information is accurate and correct to the best of our knowledge.	

RETURN FORM WITHIN 30 DAYS TO:

AmeriHealth Enrollment Department
P.O. Box 42555
Philadelphia, PA 19101-2555

01417 5/98

PRIOR CARRIER DEDUCTIBLE CREDIT INFORMATION

MEMBER SOCIAL SECURITY NUMBER: _____

GROUP NAME: _____

DATE COMPLETED: _____

MEMBER INFORMATION	INDIVIDUAL DEDUCTIBLE AMOUNT SATISFIED
NAME: _____ DATE OF BIRTH: ___/___/___	
DEPENDENT INFORMATION	**INDIVIDUAL DEDUCTIBLE AMOUNT SATISFIED**
NAME: _____ DATE OF BIRTH: ___/___/___ SEX/RELATIONSHIP: _____/_____	
NAME: _____ DATE OF BIRTH: ___/___/___ SEX/RELATIONSHIP: _____/_____	
NAME: _____ DATE OF BIRTH: ___/___/___ SEX/RELATIONSHIP: _____/_____	
NAME: _____ DATE OF BIRTH: ___/___/___ _____/_____	

PRIOR CARRIER DEDUCTIBLE CREDIT

WHAT IS PRIOR CARRIER DEDUCTIBLE CREDIT?

It's simple, if under your previous plan you incurred expenses that were credited toward your annual deductible in the calendar year or benefit period in which your group became effective, you can receive deductible credit toward your new policy with AmeriHealth.

HOW DO I KNOW IF I AM ELIGIBLE?

If you are a new AmeriHealth member and incurred expenses related to a deductible under your previous carrier, you are eligible. In order for you to take advantage of this benefit you *must* provide AmeriHealth with the required documentation, as soon as possible or no longer than 90 days after your enrollment date to receive full credit.

HOW DO I APPLY?

- Submit a copy of your most recent Explanation of Benefits (EOB) from your prior insurance carrier, complete the Prior Carrier Deductible Credit (PCDC) Form on the reverse page-side, attach your EOB(s) and submit to AmeriHealth. Included for your convenience is a Postage Paid envelope marked Prior Carrier Deductible Credit.

- Please remember you have only **90 *DAYS*** from your enrollment date to submit your EOB and PCDC form to receive full credit. After 90 days you may forfeit some or all of your credit. Since annual deductibles apply to each family member, we will need information specific to each of your dependents who will be covered. For example, a husband must submit an EOB indicating his credit to be applied and a wife will need to provide an EOB indicating her credit to be applied.

HOW WILL I KNOW IF MY CREDIT HAS BEEN APPLIED?

You will receive a letter from AmeriHealth verifying that we received your request and documentation to receive PCDC. The letter will also indicate each family member's individual amount that will be credited toward your new deductible.

PRIOR CARRIER DEDUCTIBLE CREDIT CHECKLIST:

- ❑ PCDC Form completed (first page of this form)
- ❑ Prior Carrier Credit EOB (please retain a copy for your records)
- ❑ EOB's indicating credit to be applied for <u>each</u> family member
- ❑ Mail PCDC Form and EOB(s) to:

AMERIHEALTH
Prior Carrier Deductible Credit
P.O. Box 7450
Philadelphia, PA 19101-9102

If you have any questions, please call the Customer Service number listed on the back of your Identification Card.

359C

AmeriHealth Insurance Company of New Jersey

AMERIHEALTH CLAIM FORM

(see reverse side for instruction)
Please Mail To:
AMERIHEALTH INSURANCE COMPANY
P.O. BOX 41574
PHILADELPHIA, PA 19101-1574

I. MEMBER/PATIENT

MEMBER'S NAME (First, Middle, Last)		IDENTIFICATION NO.	GROUP NO.	
PRESENT ADDRESS-STREET ❑ NEW ADDRESS		CITY	STATE	ZIP CODE
PATIENT'S NAME (First, Middle, Last)	RELATIONSHIP OF PATIENT TO MEMBER ❑ Self ❑ Spouse ❑ Child ❑ Handicapped dependent ❑ Other		SEX ❑ M ❑ F	BIRTH DATE ____/____/____

II. OTHER INSURANCE

- Does the PATIENT have additional health insurance? ❑ NO ❑ YES If yes, complete Part II:

POLICYHOLDER'S NAME	BIRTH DATE	EMPLOYMENT STATUS OF POLICYHOLDER	
	____/____/____	❑ Active ❑ Retired	❑ Disabled ❑ Effective Date: ___/___/___

Relationship of Policyholder to Member	Other Insurance Carrier's Name	Identification No.	Effective Date
❑ Self ❑ Spouse ❑ Child ❑ Other			____/____/____

TYPE(S) OF COVERAGE ❑ Hospitalization ❑ Medical-Surgical ❑ Dental ❑ Vision ❑ Drug
❑ Major Medical ❑ Other (specify) _____

CONTRACT COVERS ❑ Policyholder Only ❑ Policyholder and Spouse ❑ Policyholder and Child(ren) ❑ Family

- Is the PATIENT entitled to benefits under MEDICARE HOSPITALIZATION Insurance (Part A)?

  ❑ NO ❑ YES Effective Date ____/____/____ Medicare ID Number _____

- Does the PATIENT receive benefits under MEDICARE MEDICAL Insurance (Part B)?

  ❑ NO ❑ YES Effective Date ____/____/____ Medicare ID Number _____

If you answered "yes" to either of the above, give employment status of the Member listed in Part "I":
❑ Active ❑ Retired ❑ Disabled

III. PATIENT'S CONDITION

- DESCRIBE CONDITIONS FOR WHICH YOU ARE REQUESTING BENEFITS AT THIS TIME:

Type of Injury or Illness	Name of Doctor Treating Injury/Illness	Date of First Symptoms
A. _____	_____	____/____/____
B. _____	_____	____/____/____

- WERE SERVICES RELATED TO HOSPITALIZATION? ❑ NO ❑ YES If yes, please give:

  Date of Admission ____/____/____ Date of Discharge ____/____/____
  Hospital Name _____ Admitting Physician _____

- WERE EXPENSES DUE TO AN ACCIDENT? ❑ NO ❑ YES If yes, give type/place of accident:
  Give date of accident ____/____/____ ❑ Work ❑ Auto ❑ Other (specify) _____

- IS THIS CLAIM FOR PRESCRIPTION DRUGS? ❑ NO ❑ YES If yes, please give:

  Pharmacy Name _____ Address_____

  NDC Number (obtain from Pharmacist): _ _ _ _ _ - _ _ _ _ - _ _

IV. AUTHORIZATION

I certify that the information provided on this claim form is correct and complete, and that I am claiming benefits only for charges actually incurred by the patient named. I authorize any hospital, physician or other provider who participated in the care and treatment of the patient to release to AmeriHealth all medical or other information requested for the processing of this claim. I hereby agree to reimburse AmeriHealth in full should this claim be incorrectly paid. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

MEMBER SIGNATURE DATE	(AREA CODE) HOME PHONE	(AREA CODE) WORK PHONE

Form #19325 11/95

INSTRUCTIONS

If your provider is participating in AmeriHealth, the provider will submit a claim for you. This claim form should only be submitted when you use a non-participating AmeriHealth provider who does not submit a claim for you.

1. Please attach itemized bills to this claim form. These bills should include the following information:

    - Name, address, and telephone number (on official bill head) of the PROVIDER rendering the service or supplying the item.
    - PATIENT'S full name
    - DESCRIPTION of each service rendered or item supplied
    - DATE AND AMOUNT CHARGED for each service rendered or item supplied
    - DIAGNOSIS of ailment

2. Please be sure that a PHYSICIAN'S MEDICAL CERTIFICATION accompanies bills for:

    - Purchase or rental of medical equipment

3. When you are submitting expenses for more than one family member, please use a SEPARATE claim form for each person.

4. Please complete the claim form carefully, and be sure to include the information requested above. This will help to avoid unnecessary delays in processing your claim.

5. Prescription drug purchases made at network pharmacies do not require you to submit a claim form. The pharmacist will file the claim for you, and any resulting benefit payments will be made directly to you. If you purchase your prescription drug at a non-network pharmacy, you may still be entitled to reimbursement for a portion of your prescription drug expenses by completing Section III of this claim form. Be sure to include itemized receipts for each prescription. Remember to ask your pharmacist for the NDC number of the drug you purchase, and record that number in Section III on the front of this form.

AmeriHealth

Point of Service

TYPE OR PRINT

REMEMBER TO AVOID DELAYS, BE SURE ITEM 9, EMPLOYEE'S SOCIAL SECURITY # IS PROVIDED

INFORMATION WE NEED FROM YOU

SECTION A

I am choosing to receive covered healthcare services for myself or a dependent outside of the designated referral system. I understand that by using non-referral providers, I will be subject to a deductible, coinsurance and other co-payments, as specified in the AmeriHealth contract.

SIGNED - EMPLOYEE OR SPOUSE ✗	DATE	**THIS SECTION MUST BE SIGNED BEFORE A CLAIM MAY BE PROCESSED**

SECTION B

1. PATIENT'S NAME (FIRST, M.I., LAST) — ID #

2. PATIENT'S ADDRESS (IF DIFFERENT FROM EMPLOYEE) — STREET — CITY — STATE — ZIP CODE — HOME TELEPHONE NO. — BUSINESS TELEPHONE NO.

3. PATIENT'S DATE OF BIRTH (MONTH/DAY/YEAR)

4. PATIENT'S SEX ❒ M ❒ F

5. PATIENT'S RELATION TO EMPLOYEE ❒ SELF ❒ SPOUSE ❒ CHILD ❒ OTHER

6. SUBSCRIBER'S NAME (FIRST, M.I., LAST) — ID #

7. SUBSCRIBER'S ADDRESS AND TELEPHONE NO. — STREET — CITY — STATE — ZIP CODE — HOME TELEPHONE NO. — BUSINESS TELEPHONE NO.

8. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT ❒ YES ❒ NO — B. AN ACCIDENT ❒ YES ❒ NO — IF AN ACCIDENT — DATE — TIME ❒ AM ❒ PM — DESCRIPTION (HOW AND WHERE)

9. SUBSCRIBER'S SOCIAL SECURITY NUMBER — 10. GROUP NO. — 10a. GROUP NAME (EMPLOYER'S COMPANY NAME)

11. IS PATIENT COVERED BY ANY OTHER HEALTH PLAN? ❒ YES ❒ NO — IF YES — NAME OF POLICY HOLDER — POLICY NUMBER — NAME AND ADDRESS OF INSURANCE COMPANY

12. IS PATIENT COVERED BY MEDICARE? ❒ YES ❒ NO

13. IS CHILD FULL-TIME STUDENT? ❒ YES ❒ NO

I authorize the release of any information necessary to process this request.

14. SIGNED (PATIENT OR PARENT IF MINOR) ✗

INFORMATION TO BE COMPLETED BY PHYSICIAN

SECTION C

15. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

16. DATE FIRST CONSULTED YOU FOR THIS CONDITION

17. DIAGNOSIS, OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN BY REFERENCE TO #S 1,2,3 ETC. OR DX CODE

18. A. PLACE OF SERVICE	B. DATE OF SERVICE	C. FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES, OR SUPPLIES FOR EACH DATE				D. DIAGNOSIS CODE OR UNITS	E. CHARGES
		PROCEDURE CODE	MOD1	MOD2	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES		

19. YOUR PATIENT'S ACCOUNT NO.

20. PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER

21. ENTER THE TAXPAYER ID NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED BY LAW TO FURNISH YOUR TAXPAYER ID NUMBER.

22. TOTAL CHARGES

23. AMOUNT PAID

24. BALANCE DUE

TAXPAYER ID NO. — 25. SIGNATURE OF PHYSICIAN OR SUPPLIER — DATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any material false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. PROVIDERS: By signing this document, you swear or affirm that the services or materials for which claim is being made were necessary and were, in fact, furnished.

EMPLOYEE

1. **EACH TIME YOU REQUEST BENEFITS SIGN SECTION A AND COMPLETE SECTION B (ITEMS 1 THROUGH 14) ON THE REVERSE SIDE OF THIS FORM.**

   USE A SEPARATE BENEFIT REQUEST FORM FOR **EACH** MEMBER OF THE FAMILY.

2. ASK YOUR DOCTOR, HOSPITAL OR SUPPLIER TO COMPLETE (SECTION C THE PHYSICIAN OR SUPPLIER INFORMATION ITEMS 15 - 25) OR ATTACH ITEMIZED BILLS.

   ITEMIZED BILLS SHOULD INCLUDE:

   - DOCTOR'S NAME & ADDRESS
   - PATIENT'S NAME
   - DATE OF SERVICE
   - CONDITION BEING TREATED/DIAGNOSIS
   - CHARGE FOR SERVICE
   - TYPE OF SERVICE

SEND THIS REQUEST FOR BENEFITS TO:
AMERIHEALTH PROCESSING SERVICES
PO BOX 41574
PHILADELPHIA, PA 19010-1574

IF YOU HAVE ANY QUESTIONS, CALL:
1-800-422-2457

DOCTOR, HOSPITAL OR SUPPLIER

1. COMPLETE ITEMS 15 THROUGH 25 ON THE BENEFITS REQUEST FORM USING CURRENT CPT PROCEDURE AND ICD-CM DIAGNOSIS CODES.

2-DIGIT PLACE OF SERVICE CODES

(THE CURRENT 2-DIGIT PLACE OF SERVICE CODE MUST BE USED ON ALL CLAIMS SUBMISSIONS)

11	OFFICE
12	HOME
21	INPATIENT HOSPITAL
22	OUTPATIENT HOSPITAL
23	EMERGENCY ROOM (HOSPITAL)
24	AMBULATORY SURGICAL CENTER (ASC)
25	BIRTHING CENTER
26	MILITARY TREATMENT FACILITY
31	SKILLED NURSING FACILITY (SNF)
32	NURSING FACILITY
33	CUSTODIAL CARE FACILITY
34	HOSPICE
41	AMBULANCE (LAND)
42	AMBULANCE (AIR OR WATER)
51	INPATIENT PSYCHIATRIC FACILITY
52	PSYCHIATRIC FACILITY PARTIAL HOSPITALIZATION
53	COMMUNITY MENTAL HEALTH CENTER
54	INTERMEDIATE CARE FACILITY/MENTALLY RETARDED
55	RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITY
56	PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY
61	COMPREHENSIVE INPATIENT REHAB FACILITY
62	COMPREHENSIVE OUTPATIENT REHAB FACILITY
65	END STAGE RENAL DISEASE TREATMENT CENTER
71	STATE OR LOCAL PUBLIC HEALTH CENTER
72	RURAL HEALTH CLINIC
81	INDEPENDENT LABORATORY
99	OTHER UNLISTED FACILITY