DEGREES HEALTH

Reference Based Pricing Implementation

Plan Information

Plan Name:
Address 1:
Address 2:
City: State: Zip:

Plan Live Date:
Estimated Enrolled Employee Lives:
Plan/Group #:
Using 6 Degrees Payor ID: ☐ **Yes** ☐ **No**

Reimbursement Levels:

Included			Repricing (% CMS)	Authority (% CMS)
☐ Yes	☐ No	Facility:		
☐ Yes	☐ No	Facility OON:		
☐ Yes	☐ No	Professional:		
☐ Yes	☐ No	Professional OON:		
☐ Yes	☐ No	Drug:		
☐ Yes	☐ No	Other:		
☐ Yes	☐ No	Other:		
☐ Yes	☐ No	MediShield		
☐ Yes	☐ No	Patient Defender		
☐ Yes	☐ No	Cash Prepay		

If Facility Only - List Provider Network:

☐ Claims Repriced to Direct Contract with:

Plan Design:

*If known, please include plan design details below. All high deductible plans must be filled in.

Group Number	High Deductible Plan	Individual Deductible	Family Deductible	Max Individual OOP	Max Family OOP
	☐ Yes ☐ No				
	☐ Yes ☐ No				
	☐ Yes ☐ No				

Brokerage Company:
Broker Name:
Broker Email:
Broker Phone:

TPA Name:
Contact Name:
Contact Email:
Contact Phone:

Medical Management Company:

Captive Name (if applicable):

Stop-loss Carrier/MGU (if applicable):

Monthly Reporting Contacts:

Implementation Checklist:

Documents to send to 6 Degrees Health:

- ☐ New Plan Info Sheet
- ☐ TPA Contact List
- ☐ ID Card Template for approval
- ☐ Request for Plan URL landing page
- ☐ Draft Plan Document for review
- ☐ Final Plan Document

Before Plan Live Date:

- ☐ Request Member FAQ Sheet
- ☐ Share Member RBP Introduction Video
- ☐ Set Up Monthly PEPM Payments
- ☐ Automate Weekly Eligibility File

PLEASE SEND ALL REQUESTS AND DOCUMENTS TO YOUR DESIGNATED ACCOUNT MANAGER AND PROJECT MANAGER ON THE 6 DEGREES HEALTH CONTACT LIST.

Plan acknowledges that all information contained in this plan information sheet is true and accurate to the best of its knowledge and the signature below represents that (s)he is an authorized representative of the Plan.

Signature:

Name:
Company:
Date: