

**Company Name:** \_\_\_\_\_

Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Toll-Free: \_\_\_\_\_  
Web site: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Mailing Address:**

Company Name: \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

**OFFICERS (If actual title varies, please cross out and write in correct title):**

- Chairperson of Board: .....
- Chief Executive Officer: .....
- President/Director: .....
- Chief Financial Officer: .....
- Medical Director: .....
- Chief Information Officer: .....
- Marketing Director/ Sales Director: .....
- Chief Operations Officer: .....
- Pharmacy Director: .....
- MIS Director: .....
- Privacy Officer .....
- Credentialing Officer/Director .....
- Public Relations Director: .....
- Director of Provider Services: .....
- Director of Network Operations/Development: .....
- Director of Case Management: .....
- Director of Health Promotion/Prevention: .....
- Director of Human Resources: .....
- Director of Medical Management: .....
- Director of Quality Assurance: .....
- Director of Fraud Prevention/Investigation: .....
- Director of New Product Development: .....
- Director/Coordinator of Managed Care .....

**COMPANY PROFILE:**

Parent Company Name: \_\_\_\_\_  
 Doing Business As: \_\_\_\_\_  
 Year Founded: \_\_\_\_\_ Federally Qualified? (Y or N) [ ] For-Profit? (Y or N) [ ] Not-For-Profit: [ ]  
 Model Type: Group [ ] IPA [ ] Network [ ] Staff [ ] Mixed [ ]  
 Plan Type: HMO [ ] PPO [ ] Specialty HMO [ ] Specialty PPO [ ] CDHP [ ] HDHP [ ]  
 POS [ ] ASO [ ] PRO [ ] TPA [ ] EPO [ ] UR [ ] HSA [ ]  
 Are you owned by an IDS? [ ] Integrated Horizontal: [ ] Integrated Vertical: [ ]  
 If yes, please list IDS system name & state: \_\_\_\_\_  
 Are you Physician/Provider owned: [ ]Yes [ ]No

**Plan Statistics:**

Bed Days Under 65 (per 1000): \_\_\_\_\_ Bed Days over 65 (per 1000): \_\_\_\_\_  
 Primary Physicians: \_\_\_\_\_ Physician Specialists: \_\_\_\_\_  
 Hospitals: \_\_\_\_\_  
 Revenues: Total Revenues 2004: \$ \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ 2005: \$ \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 Net Income 2004: \$ \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ 2005: \$ \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 Type of Accreditation: [ ] NCQA [ ] URAC [ ] JCAHO [ ] AAPPO  
 Medical Loss Ratio: 2004: \_\_\_\_\_:\_\_\_\_\_ 2005: \_\_\_\_\_:\_\_\_\_\_  
 Administrative Expense Ratio: 2004: \_\_\_\_\_:\_\_\_\_\_ 2005: \_\_\_\_\_:\_\_\_\_\_

**Type of Coverage:**

Commercial: [ ] Individual: [ ] FEHBP: [ ] Indemnity: [ ]  
 Medicare: [ ] Supplemental Medicare: [ ] Medicaid: [ ]

**Plan Benefits (check all that apply):**

Chiropractic: [ ] Dental: [ ] Home Care: [ ]  
 Inpatient SNF: [ ] Long-Term Care: [ ] Pharm. Mail Order: [ ]  
 Podiatry: [ ] Psychiatric: [ ] Spclty Behavioral Hlth: [ ]  
 Spclty Physical Therapy: [ ] Transplant: [ ] Vision: [ ]  
 Wellness: [ ] Workers' Comp: [ ] Disease Management [ ]  
 Alternative Med: [ ] Other Specialty: \_\_\_\_\_

**Enrollment Demographics:**

Total Enrollment:	2004:	2005:	2006:
<b>Enrollment By Coverage:</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Individual:			
Commercial:			
Medicare:			
Supplemental Medicare:			
Medicaid:			
Indemnity:			
FEHBP:			
<b>Enrollment By Plan Type:</b>			
HMO:			
PPO:			
POS:			
EPO:			
Specialty HMO:			
Specialty PPO:			
ASO:			

**ENROLLMENT BY GEOGRAPHIC AREA:** (List enrollment per each state, ie., NJ 1,000; CT 2,000)

**SERVICE AREA** (please list states & counties served — attach additional sheet if necessary):

Nationwide? [ ]

**PRODUCTS OFFERED** (attach additional sheet if necessary):

Product Name	Coverage Type	Enrollment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**INFORMATION SYSTEMS:** What system do you use for your managed care information system? (Used to process claims)

Company Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

**PHARMACY BENEFIT MANAGEMENT STRATEGIES:**

Do you use a pharmacy benefit management company? [ ] Yes [ ] No

If yes, please list

PBM Company: \_\_\_\_\_

Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

**EMPLOYER REFERENCES:**

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



**This a FREE Listing in  
 The National Directory of  
 Managed Care  
 Organizations**

Mail or fax it back to us at the  
 Managed Care Information Center,  
 Dept. 14D,  
 PO Box 456,  
 Allenwood, NJ 08720;  
 Toll-Free 888-843-6242  
 Fax 888-329-6242