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## TPA Questionnaire

### Part I – Entity, Location, Ownership, Affiliation

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

T.I.N. # \_\_\_\_\_ Type of Business: Corporation, Partnership, Sole Proprietor (Circle One)

List of Officers: *(Attach additional list if necessary. Submit resumes of Officers, Directors and Owners)*

President \_\_\_\_\_

Secretary \_\_\_\_\_

Vice Pres. \_\_\_\_\_

Treasurer \_\_\_\_\_

Please list other companies with whom you have financial interest (i.e., insurance companies, PPOs, HMOs, MGUs, Brokerage operations, etc.)

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

In the last 5 years has your business entity ever been involved in a merger?  Yes  No

If yes, please describe:

\_\_\_\_\_

In the last 5 years has your business entity ever had a change in ownership?  Yes  No

If yes, please describe:

\_\_\_\_\_

Has your business entity had a change of name, and /or use a d.b.a. or is it operating under an assumed name?  Yes  No; if yes, previous name was \_\_\_\_\_

How do you produce business? (Check all that apply).

- TPA Staff Direct
- Independent Brokers/Agents
- Other, define \_\_\_\_\_

If you use independent brokers/agents to produce business, is their compensation for service paid by:

- Client directly
- TPA
- Other, define \_\_\_\_\_

How do you disclose fees, compensation, to the client? (Check all that apply).

- In the proposal offer
- In the service agreement
- At time of 5500 filing
- Other, define \_\_\_\_\_

Branch Offices: (*Attach additional list if necessary*)

NAME, ADDRESS, PHONE, FAX, CONTACT

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**Part II – Systems/Administration and Claims (Hardware & Software)**

	Administration	Claims
1. Is system on-line or manual?	_____	_____
2. What is the name of the software system?	_____	_____
3. Who developed the system?	_____	_____
4. What is the year of development?	_____	_____
5. Is software lease, timeshared, or owned?	_____	_____
6. If owned, what is the year purchased?	_____	_____
7. What is the Name/type of hardware?	_____	_____

8. Is hardware leased, timeshared or owned? \_\_\_\_\_
9. Have you changed or upgraded systems? \_\_\_\_\_
- If Yes please describe: \_\_\_\_\_

**Part III - Administrative Services (Financial, Eligibility and Premium Accounting)**

Staff: Total number of employees in Department: \_\_\_\_\_

Name of key Personnel & Managers	Job Title	Years Experience
_____	_____	_____
_____	_____	_____
_____	_____	_____

If necessary, list additional names on a separate page & attach. *Please attach resumes.*

1. May clients have system access in their offices?  Yes  No;  
If yes, which administrative functions can the client perform? \_\_\_\_\_
2. Can you provide census and premium data electronically?  Yes  No
3. System(s) Security & Audit Procedures:
  - A. Describe Security for master file: (i.e., who can enter new groups, changes).  
\_\_\_\_\_
  - B. Describe security for client funds.  
\_\_\_\_\_
  - C. Describe record retention program for enrollment cards, billing files, etc.  
\_\_\_\_\_
  - D. Describe back-up system in the event that the computer master file is destroyed.  
\_\_\_\_\_
4. Does your system calculate individual or group premium?  Yes  No  
Or, are they manually calculated and entered in the master file?  Yes  No

5. Describe procedures for adding, deleting and changing Plan Participants and their benefits.

\_\_\_\_\_

6. Do you perform bank account reconciliation on Client Accounts?  Yes  No

7. How often do you generate premium billings? \_\_\_\_\_

8. On what days do you generate premium billings? \_\_\_\_\_

9. When are premium reminder notices sent? \_\_\_\_\_

10. When are lapse notices sent? \_\_\_\_\_

11. On what dates(s) are premium payments run for insured & reinsures? \_\_\_\_\_

NOTES/COMMENTS: \_\_\_\_\_

**Part IV – Claims Administration**

Staff: Total number of employees in: Adjudication \_\_\_\_\_ Support \_\_\_\_\_ Managers \_\_\_\_\_

Name of key Personnel & Managers	Job Title	Years Experience
_____	_____	_____
_____	_____	_____
_____	_____	_____

If necessary, list additional names on a separate page & attach. *Please attach resumes.*

1. How many terminals are in use? \_\_\_\_\_

2. Is eligibility determined on-line?  Yes  No

3. How long is claim history maintained on-line? \_\_\_\_\_

4. Has the department been audited by a third party for accuracy/security?  Yes  No

If yes, how recently? Give name of audit firm: \_\_\_\_\_

and type of audit: (check all that apply).

CPA/5500  CPA/Performance  Carrier/MGU  Independent Claims Audit

5. Can you provide claim data electronically?  Yes  No

6. Claims are largely (i.e.: +75%)

a) Processed: Manually\_\_\_\_\_ on-line\_\_\_\_\_

b) Filed: By family\_\_\_\_\_ by day batch\_\_\_\_\_

7. What does a claim represent? (Check one)

Line item  Check EOB other\_\_\_\_\_

Based on the above definition, what is the average number of claims processed by adjuster per hour \_\_\_\_\_.

8. What is your payment accuracy objective?

a) Statistical: Number of claims paid \_\_\_\_\_

b) Financial: Dollar amount paid without error \_\_\_\_\_

9. Describe the payment authority limitation for the claims staff and describe the criteria for internal audits.

\_\_\_\_\_

10. What is your payment accuracy performance during the last twelve months? \_\_\_\_\_

11. What is your turnaround objective? \_\_\_\_\_

12. What is your turnaround time over the last twelve months?\_\_\_\_\_

13. Surgical R&C is based upon: HIAA  Internal  MDR  Med-Index  Other;

If other, please describe:

Surgical: \_\_\_\_\_

Medical: \_\_\_\_\_

Dental: \_\_\_\_\_

14. Is your R&C database on-line?  Yes  No

15. How often is R&C data updated? \_\_\_\_\_

16. Are ICD-9 codes captured?  Yes  No

17. Are CPT codes captured?  Yes  No

18. For what period of time are hard copy claims files retained? \_\_\_\_\_

19. Are separate bank accounts maintained for each client?  Yes  No

a) What is included in each account? \_\_\_\_\_

b) Who has disbursement authority? \_\_\_\_\_

c) Is there is a trust established for Funded Plan?  Yes  No

Describe a "typical" clients funds transaction through your office. \_\_\_\_\_

\_\_\_\_\_

20. Do you subcontract any data processing activities?  Yes  No. If yes please specify.

\_\_\_\_\_

21. Do you utilize off site or home claim processors?  Yes  No

22. Describe your procedures for professional Medical & Dental Claim review:

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

23. Describe your procedures for auditing and/or negotiating provider bills:

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

24. Describe your procedures for using Large Case Management (LCM):

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

25. Describe the Managed Care Procedures you are using:

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

**Part V – Carrier Relationships**

1. Please list the stop-loss carriers with which you have business:

<u>Carrier Name (MGU)</u>	<u>Number of Cases</u>	<u>Number of Employee Lives</u>	<u>Annual Premium \$</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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2. Has any carrier terminated their relationship with you in the last 5 years?  Yes  No

If yes, who and why \_\_\_\_\_

NOTES: \_\_\_\_\_

**Part VI – Compliance and Legal License**

1. Describe any previous or pending material lawsuits in the last 10 years. (*Attach additional comments if necessary*)

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2. Have any of the principals in your firm or any of your employees (former or current) ever been indicted or convicted of mishandling/misappropriating any insurance company or client funds?  Yes  No; if yes, please give details. \_\_\_\_\_

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3. Describe your current procedures for handling client or insured complaints and State Insurance Department complaints. \_\_\_\_\_

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4. Has the TPA or its principals ever been adjudged bankrupt?  Yes  No; if yes, please explain. \_\_\_\_\_

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5. Have you been involved in an audit by the *Department of Labor*?  Yes  No; if yes, please give details. \_\_\_\_\_

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6. If your operating jurisdiction(s) requires licensing, are you licensed as a:

Third Party Administrator  Managing General Agent  Agency  Broker  Agent

*Please attach a copy of current license(s) listed above.*

7. How are you kept informed of changing legal requirements within your market area?

\_\_\_\_\_

How do you inform your clients of these changes? \_\_\_\_\_

**Part VII – Insurance Bonds**

1. Do you carry an Errors and Omissions Policy?  Yes  No (*Attach copy of cover page*)

2. Do you carry a Fidelity Bond?  Yes  No (*Attach copy of cover page*)  
If you do not have a Fidelity Bond, please provide a copy of your last fiscal year income statement and balance sheet.

3. Do you carry a Professional Liability Policy?  Yes  No (*Attach copy of cover page*)

4. Do you require employee bonding?  Yes  No If yes, which employees? \_\_\_\_\_

5. Have claims been made against any of these policies in the past two years?  Yes  No

If yes, please provide details. \_\_\_\_\_

**Part VIII – Financial**

1. May we conduct an initial and ongoing financial review of your organization and/or principals using an independent agency, such as Equifax or Dun & Bradstreet?

Yes  No; if no why not? \_\_\_\_\_

2. Principal Banking relationship (to be used as a reference):

Name of Bank \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Contact \_\_\_\_\_

Contact Title \_\_\_\_\_

**Part IX – Attachments**

If one of these cannot be provided, please explain \_\_\_\_\_

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Please use this checklist and provide the following attachments.

- Resumes of Officers, Directors, Owners, and Key Personnel
- Errors and Omissions Policy Cover Page
- Professional Liability Policy Cover Page
- Fidelity Bond Cover Page now in effect or  
Last 2 Fiscal Years Income Statement and Balance Sheet
- Copy of TPA, MGA, Agency, Broker and Agent License for **each** applicable state
- Marketing Proposal
- Marketing Brochure
- Sales Literature on PPO and Managed Care
- Service Agreement
- Premium Account Flowchart/Description
- Claim Account Flowchart/Description
- Sample Billing
- Disclosure Form (P.T.E. 77-9)
- Evidence of Good Health Form
- Samples of Administrative Services Reports available to insurers and/or reinsurers
- Samples of Claims Reports available to insurers and/or reinsurers
- Sample Plan Document

*I certify that the information on this application is accurate to the best of my knowledge and belief. I understand that a routine inquiry may be made of any or all of the individuals and firms noted herein as references.*

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

TITLE \_\_\_\_\_