ENCORE HEALTH NETWORK

GROUP NOTIFICATION FORM

Company Name: *(as it will appear on the ID card)*		Effective Date:
Address/City/State		Employer Group #:
Total #Employees:	Total # Employees choosing Encore:	☐ Self Insured ☐ Fully Insured
Employer Contact Name: Title:	Telephone #:	E-mail address:

Other locations outside Indiana Accessing Encore: ☐ YES ☐ NO (If more than 1 add sheet)	If yes: Address/City/State: ______________________________ ______________________________ and # of employees: ______________
Other Managed Care Network(s)? ☐ YES ☐ NO	If YES, In Indiana: ______________________________ Outside Indiana: ______________________________

Plan Benefit Information:	In Network %: _________	Out of Network% :_________

Broker Name:	Address:
E-mail Address:	Telephone #:

Comments:

PRODUCTS AND SERVICES

☐ Encore Only ☐ Encircle Only ☐ Encircle/Encore Combined ☐ Travel NetworkOnly ☐ Dental	☐ New to Encore ☐ New to Encircle ☐ Existing Group/changing products or adding special arrangement ☐ Existing Group/New Payor; If applicable, identify previous Payor and term date:______________________________ ☐ TERMINATION: date_________ Reason for Termination:________ ______________________________ ______________________________
SPECIAL ARRANGEMENTS ☐ Client Specific Discount	**CLAIMS RUN IN:** ☐ YES ☐ NO IF YES, beginning date_________ *(Encore can only do run in for existing groups changing payors)*

ACCESS FEES:

☐ Encore Network $5.00 PEPM ☐ Encircle Network (Encore must reprice) $6.50 PEPM

☐ Encircle/Encore Combined Network(Encore must Reprice) $6.50 PEPM

☐ ____ % of Savings ☐ Other_______________

PAYOR	Name:	
	Claims Shipping Address:	
	Claims Eligibility Telephone:	Fax #:
REPRICER	Name:	
	Address:	
	Telephone:	Fax #:
UTILIZATION MANAGEMENT	Name:	
	Address:	
	Telephone:	Fax #:

Form Completed By:______________________________Title/ Company:______________________________

Phone:______________________________ E-mail Address: ______________________________ Date :___________

Please forward the completed form along with the following required documents via e-mail to Kevin McShay kmcshay@encoreppo.com

☐ Completed Information Sheet ☐ Eligibility Information ☐ Schedule of Benefits ☐ Copy of Pre-approved Identification Card ☐ Copy of EOB

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