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119 Van Buren, Ste. 10
Harlingen, TX 78550
Main: (956) 983-9272
Cell: (918) 231-9400

Frontier Health Plans

Intake Form

Please review the information in each tab and provide any available information.

***Please send all captive RFPs to:

Sales@frontier.health

General Information

Group Name:	
Group HQ Address:	
Group HQ City:	
Group HQ State (XX):	
Group Zip Code (XXXXX):	
Current Carrier:	
Current Funding Arrangement:	
Current Effective Date:	
Requested Captive Effective Date:	
Industry Code (NAICS or SIC):	
Advisor Agency Name:	
Advisor Rep/Producer Name:	
Advisor Agency Address:	
Current Broker Compensation (PEPM Consulting Fee):	
Current Broker Compensation (% Stop Loss Commission):	
Frontier Health Advisor Success Manager:	
Administrator/TPA Choice:	
Provider Network:	
PBM Choice:	
Reference Based Pricing Yes/No:	
Number of Subscribers:	(Minimum of 50 enrolled required)

Quote Details

Desired Contract Type*:	
Specific Deductible 1**:	
Specific Deductible 2**:	
Specific Deductible 3**:	
Aggregating Specific:	
Aggregate Corridor:	

Health Plan or Program you would like pricing for (Select all that apply):

___Frontier Health - Bolt On (Frontier Direct Care / Frontier Rx / Frontier Direct Pay

___Frontier Health - Full Health Plan (Frontier + TPA / PBM / SL / Captive)

- ___Level-Funded
- ___Self-Funded

___Frontier Health - Virtual (Employees living 20+ miles outside servicable Frontier clinic

___TytoCare (Virtual Exam Devices)

Additional Notes:

Frontier Health Plans

Data Requirements

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rfp@frontierdirectcare.com

Fully Insured (Limited or No Claims Data)

Member Level Census REQUIRED, and to include (must have these elements) - no middle initials or suffix
First Name
Last Name
Gender (M/F)
Date of Birth (MM/DD/YYYY)
Zip Code (5 digit)
Subscriber Relationship (Subscriber, Spouse, Child, Legal Dependent)
Tier Election (EE Only, EE+Spouse, EE+Children, Family, Waived, Waiting Period, Not Eligible, Refusing Coverage)
COBRA Indicator (Y/N)
State (XX)
Plan Election

Current Year, Prior Year and Renewal Year Rates (must include a copy of the Carrier renewal proposal)
Current and Renewal Plan Design Details (Including any requested future changes) - Summary is preferred

Level Funded or Fully Insured (Monthly Claims Data Available)

Member Level Census to include (must have these elements):
First Name
Last Name
Gender (M/F)
Date of Birth (MM/DD/YYYY)
Zip Code (5 digit)
Subscriber Relationship (Subscriber, Spouse, Child, Legal Dependent)
Tier Election (EE Only, EE+Spouse, EE+Children, Family, Waived, Waiting Period, Not Eligible, Refusing Coverage)
COBRA Indicator (Y/N)
State (XX)
Plan Election

Current Year, Prior Year and Renewal Year Rates (must include a copy of the Carrier renewal proposal)
Current and Renewal Plan Design Details (Including any requested future changes) - Summary is preferred

Claims data to include:
Minimum 12 months of Monthly Medical/Rx Claims Data
Monthly Enrollment Data that matches up with medical/rx data
Large claims data, including diagnosis information, that coincides with the monthly data (should cover same time periods as monthly data)

Self Funded

Employee Census to include (must have these elements):
Date of Birth (MM/DD/YYYY)
Gender (M/F)
Zip Code (5 digit)
Plan Election
Tier Election (EE, EE+SP, EE+CH, EE+CHILDREN, FAMILY)
COBRA Indicator (Y/N)
Retiree Indicator (if applicable)

24 months of Monthly Medical/Rx Claims Data (Aggregate Reports are acceptable)
Monthly Enrollment Data that matches up with medical/rx data
Large claims data, including diagnosis information, that coincides with the monthly claims data (should cover same time periods as monthly data)
Current Year and Renewal Year Rates
Current and Renewal Plan Design Details (Including any requested future changes) - Summary is preferred

FirstName	LastName	Gender	DOB	ZipCode	Relationship	CoverageType	COBRA	Plan Election	HQ State
John	Doe	Male	7/25/1973	39208	Sub	EE	N	$500 Ded	AZ

Relationship Definition	
Sub	Subscriber
Sp	Spouse
Ch	Child
LD	Legal Dependant

Coverage Type Definition	
EE	Employee Only
ES	Employee + Spouse
EC	Employee + Child(ren)
Fam	Employee + Family
WO	Waived-Other coverage
WP	Waiting Period
NE	Not Eligible
RC	Refusing Coverage