

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4402 INSTRUCTIONS

IMPORTANT: Without the signature of an authorized individual from the company, no information will be recorded. Please refer to “Signature Section” below.

This form must be completed by a payor whose status has changed from the original election submission filed.

Effective Date of Change: Enter effective date of status change.

Payor Information: Enter payor name, federal employer identification number (FEIN), contact, and phone #.

SECTION I:

Check applicable box: Check appropriate box to reflect the following status changes: self-insured to fully insured; closed/out of business; bankrupt; or other. The section “other” is not to be completed to reflect a status change resulting from a change in third-party administrator (TPA)/administrative services only (ASO), rescission, or merger.

If a TPA/ASO was utilized, provide TPA/ASO name.

Check applicable box:

Check box #1 if you or your TPA/ASO will continue to file reports for claims that have not been adjudicated for the period for which you were an elector.

Check box #2 and fill in effective date if all claims for the period in which you were an elector have been adjudicated.

Comments: Provide detailed explanation for status changes “bankruptcy” or “other”.

SECTION II:

Complete **only** if updating a previously submitted Payor Status Change form¹ (DOH-4402) to indicate a final adjudication date. If a TPA/ASO was utilized, provide TPA/ASO name.

Signature Section:

An authorized individual from the company is **required** to sign and date the form.

¹ Formerly known as Attachment 2.5

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

This form is to be completed to reflect the following status changes: self-insured to fully insured; closed/out of business; bankrupt; or other. The section "other" is not to be completed to reflect a status change resulting from a change in third-party administrator (TPA)/administrative services only (ASO), rescission, or merger.

EFFECTIVE DATE OF CHANGE: _____

Payor Name: _____ **Payor FEIN:** _____

Contact Person: _____ **Phone #:** _____

SECTION I

Check applicable box:

- SELF-INSURED TO FULLY INSURED** **CLOSED/OUT OF BUSINESS** **OTHER**
 BANKRUPTCY Chapter 11 Chapter 7

TPA/ASO Name: _____

Check applicable box:

1. Reports will continue to be filed until all claims have been adjudicated, at which time Section II of this form will be submitted indicating final adjudication date.
2. All claims have been adjudicated effective _____.

COMMENTS (Provide detailed explanation for status changes "bankruptcy" or "other").

SECTION II (Complete only if updating a previously submitted Payor Status Change form (DOH-4402) to indicate a final adjudication date)

All self-insured claims have been adjudicated effective _____.

TPA/ASO Name: _____

Signature of Payor _____ **Date** _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757