HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4403 INSTRUCTIONS

This form is to be completed by a payor whose status has changed from the original election as it relates to whether a TPA/ASO is utilized for claims processing.

Effective Date: Enter effective date of status change.

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

Type of Status Change: If you are adding or changing a TPA/ASO organization, check appropriate box on type of status change being submitted.

Previous TPA/ASO Information: Enter previous TPA/ASO name/FEIN, if applicable.

New or Additional TPA/ASO Information: Enter new or additional TPA/ASO name, FEIN, address, contact person, and phone number.

Check one of the following: Check appropriate box regarding claims run out, if applicable.

Signature Section: An authorized individual from the electing payor's company must sign and date the form.

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Finance and Rate Setting

Third Party Administrator (TPA) or Administrative Services Only (ASO) Status Change

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

This form must be completed if an electing payor is adding or changing their TPA/ASO.

Effective Date:_____

PAYOR INFORMATION:

Payor Name: _____ Payor FEIN: _____

Contact Person: _____ Phone #: _____

Type of Status Change (check appropriate box):

☐ **Additional TPA/ASO** (complete Section II only)

☐ **Changing TPA/ASO** (complete Sections I, II & III)

I. PREVIOUS TPA/ASO INFORMATION:

TPA/ASO Name: _____ TPA/ASO FEIN: _____

II. NEW or ADDITIONAL TPA/ASO INFORMATION:

TPA/ASO Name: _____ TPA/ASO FEIN: _____

Address: _____

_____

TPA/ASO Contact Person: _____ TPA/ASO Phone #: _____

III. CHECK ONE OF THE FOLLOWING:

☐ Previous TPA/ASO will continue to process claims and file reports for all dates of service prior to the change for a period of one year following the end of the year in which the change in TPA occurred or until all such claims have been adjudicated, at which time a final monthly report with a copy of this form indicating same will be filed.

☐ All self-insured claims that previous TPA/ASO was responsible for have been adjudicated effective_____.

☐ New TPA/ASO is assuming responsibility for all pending claims and HCRA reporting requirements.

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