

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL
DOH-4401 INSTRUCTIONS

Must be completed by TPA/ASO for electing clients, which are being added to the original election submission filed.

Note: This form is to be utilized by a TPA/ASO and acts as an addendum to their originally filed election application for adding new electing clients or in the case where a TPA/ASO is adding a new client that previously elected under another TPA/ASO.

The form is to be completed as follows:

TPA/ASO Name: Enter name of TPA/ASO.

TPA/ASO FEIN: Enter FEIN of TPA/ASO.

Contact Person: Enter name of person responsible for providing the Department or providers related information regarding the elections of a TPA's/ASO's represented funds.

Phone #: Enter phone number of the contact person.

Additions: List each organization's legal name, FEIN, contact email address and start date that is being added to your original election submission. The start date is the payor's effective date (if a newly electing payor) or the date the electing payor became your client.

<p><u>Please mail completed form to:</u> 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</p>
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HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Must be completed by TPA/ASO for electing clients being added to the original election submission filed.

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

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

ADDITIONS:

For each organization being **added**, include a separate Election Form (Payor Election Application (DOH-4399) and Electronic Filing User ID Application (DOH-4264)) unless the organization previously filed an election application and is on the NYS Department of Health’s website elector list (www.health.state.ny.us/nysdoh/hcra/hcrahome.htm)

List those organizations you represent, and are **adding** to the original election submission, that elect to make direct payments to the Department’s Office of Pool Administration. Attach additional sheets if necessary.

ORGANIZATION NAME (Legal Name)	ORGANIZATION FEIN	ORGANIZATION CONTACT (Email address)	START DATE

By signature below, the TPA/ASO on behalf of the direct payor clients listed above who have elected to make public goods surcharge payments directly to the Department’s Office of Pool Administration, certifies that its original election certification continues and is extended to encompass the newly represented clients listed above.

Signature _____

Date _____