

**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.

**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