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 form\(^1\) (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