

Contact Designation Form

for CLAIM OFFICE / MEDICAL BILLING / UNDERWRITER / ADMINISTRATOR

Please see the reverse side of this form for completion instructions

This form is being filed for:

An Insurance Carrier
 A Self-Insured Employer or Group

Insurance Carriers - Please complete the following	
NAIC Company Number	NAIC Group Number

Company Name (full legal) _____ **FEIN** _____

Claim Office:

Claims are: Self-Administered (see below)
 Handled by a TPA

Company Name _____

Physical Address * _____

(Bldg/Suite#) _____

City/St/Zip _____

If claims are handled by a TPA, stop here. Complete the following only if claims are self-administered

Mailing/Scanning Address _____

(Bldg/Suite#) _____

City/St/Zip _____

* The physical address above will be used solely to identify/approve the claim office handling claims. All postal mail, including certified mail, will go to the mailing/scanning address. Complete the mailing address information even if it is the same as the physical address. Do not indicate "same as above".

The Commission allows the use of a general/generic e-mail address for claim specific notices. Claim specific e-mail notices will go to the contact person designated for the physical address from which the claim was filed and to this address if provided.

General/Generic Claim _____

Office E-Mail Address _____

Provide the contact person and information for the claim office at the physical address above

Contact Name (Mr./Ms.) _____

Direct Dial Phone _____

Fax _____

Toll Free _____

E-mail (Person Specific) _____

Medical Billing:

Do not use a bill review company's information for this section

Company Name _____

Mailing Address _____

(Bldg/Suite#) _____

City/St/Zip _____

Phone _____

Fax _____

E-mail _____

** Medical bills must be able to be received via US Mail, Fax, and E-mail

Underwriting:

Coverage verification

Company Name _____

Mailing Address _____

(Bldg/Suite#) _____

City/St/Zip _____

Contact Name (Mr./Ms.) _____

Direct Dial Phone _____

Fax _____

Toll Free _____

E-mail (Person Specific) _____

Administrator:

Legal / Compliance Contact

Company Name _____

Mailing Address _____

(Bldg/Suite#) _____

City/St/Zip _____

Contact Name (Mr./Ms.) _____

Direct Dial Phone _____

Fax _____

Toll Free _____

E-mail (Person Specific) _____

I, _____ (printed name), as the designated Administrator contact of the above carrier/self-insured employer (or its parent company), make the above designations in compliance with Commission Rule 099.29. Further, we agree to promptly notify the Commission of any changes to the above designations by re-completing and submitting this form.

Signature _____ Title _____ Phone _____

_____ Date _____

Completion Instructions

Commission Rule 099.29 requires the designation of certain contacts to facilitate compliance with Arkansas law, Commission Rules and the processing of claims. Each insurance carrier (underwriting company) or approved self-insured employer/group is to complete the Form O. The designations below are to be made only by insurance carriers or self-insured employers/groups. This form is not to be completed by third party administrators, insurance agents or brokers.

Please complete all four (4) sections. When submitting the Form O, only page 1 need be submitted (do not send the completion instructions).

Company Name: This is the insurance carrier or approved self-insured employer/group for which the Form O is being completed.

Claim Office: This is the office designated, by the carrier or self-insured employer/group, to be responsible the receiving, processing, adjusting, and submission of forms, or otherwise handling of any Arkansas workers' compensation claim. Any office whether serving as the designated claim office or reporting claim office shall be approved by the Commission prior to handling any Arkansas workers' compensation claims.

Indicate if claims are self-administered or handled by a third party administrator (TPA). The physical address of the claim office must be provided. If the claim office is to receive postal (including certified) mail at a P. O. Box or scanning center address, provide that address in the mailing address section. If the mailing address is the same as the physical address, repeat the physical address information in the mailing address section. Do not indicate "same as above". A general/generic e-mail address for the claim office is now being allowed. Claim specific E-mail notifications will go to the new claim office e-mail address as well as to the contact person for the claim office reporting the claim.

Only if claims will be self-administered, does a contact person need to be named. This person must maintain an office in the claim office location, and should have sufficient authority to address and resolve any issues that may arise regarding claim adjusting, payment of medical bills, timeliness/accuracy of form filings, or any other claim specific issue or process relating to claims. Typically we look for a managerial level employee for this contact. The e-mail address listed is to be the e-mail address of the person serving as the contact.

If the designated claim office is that of a Third Party Administrator (TPA), only the company name and physical address of the office that will actually handle the claims needs to be provided in this section. The TPA companies have previously provided a mailing address, general/generic e-mail, and a contact person for each approved location.

If an insurance company designates its own claim office (or claim office within the corporate family of the underwriting carrier) and also utilizes the services of a TPA for specific insured employers, the designated claim office is to have the ability to identify and refer any claim specific item to the TPA office handling the claim (reporting office).

Medical Billing: Each insurance carrier or approved self-insured employer/group is to provide a designated billing location, including: mailing address, e-mail address, fax number, and phone number, for medical billing. This is to be a location under the direct control of the insurance carrier or self-insurer/group. Location/contact information of a bill review company will not be acceptable. If a carrier's claims are handled by a single TPA, the carrier may provide information of the TPA for billing purposes.

The medical billing information will be provided to medical providers upon request, or any other person, for the submission of medical or claim related bills. The e-mail address provided in this section may be a general/generic e-mail address. The designated billing location shall be responsible for forwarding any bill to the appropriate office for processing.

Underwriting: It is not required that the person designated for this contact be a true underwriter. We simply need a person capable of verifying insurance coverage and/or can provide a certificate of insurance to the Commission for any employer claiming coverage with that underwriting company. Self-Insured employer and self-insured groups do not need to complete this section.

Administrator: This person is to be an employee of the underwriting carrier, or an employee within the underwriting company's corporate family. This person is to have an overall compliance role with the authority to resolve any workers' compensation matter, including, but not limited to, claims. Typically, this person is responsible for filing and payment of premium taxes, maintaining contact information with the Commission, and maintaining the company's license to write workers' compensation or to self-insure in Arkansas. For Self-Insurers, this is the person responsible for the self-insurance program. **No changes to the contact information will be made without the Administrator's consent/approval as evidenced by their signature on the Form O.**