

Health One

New Client Information Form

Date: _____

Effective date: _____

Legal Company Name: _____

Company contact: _____

Address: _____

Phone number: _____

Fax: _____

Subsidiaries: None

of employees: _____

Amount of Administrative Fee: \$3.00

Who is billed: _____

Address: _____

Phone Number: _____

SERVICE AREA **Entire HOA network service area:**

TPA: _____

Contact: _____

Address: _____

Claims address: _____

Benefit Verification and Claims Status #: _____

Pre-Certification Company: _____

Fax: _____

Pre-Certification #: _____

Contact Name: _____

Pharmacy Benefit Company: _____

Group #: _____

Pharmacy Number: _____

Plan percentage: _____

Plan document received: _____

Repricing agent: _____

Office Co-Pay: _____

Deductible Amounts: _____

Group Number: _____

Account Rep: PB

Health cards sample:

Date sample received: _____