STATEWIDE INSURANCE FUND REQUEST FOR PROPOSAL

MANAGED CARE FOR WORKERS COMPENSATION CLAIM FOR FUND YEAR 2012

AMENDMENT TO ORIGINAL RFP ISSUED 9/23/2012

CORRECTED DATES CONTAINED IN THE RFP

ATTACHMENT OF MEDICAL BILLS FOR REPRICING

AMENDED REPLY DATE TO OCTOBER 11, 2011 at 2 pm
STATEWIDE INSURANCE FUND REQUEST FOR PROPOSAL

MANAGED CARE FOR WORKERS COMPENSATION CLAIMS FOR FUND YEAR 2012

DATE ISSUED: 9/23/2012

REPLY DATE: 10/7/2011 NO LATER THAN 2 PM
1.0 Information for Bidders

Purpose and Intent

This Request for Proposal (RFP) is issued by the Statewide Insurance Fund (SIF). The purpose of this RFP is to solicit proposals to provide managed care services for the Statewide Insurance Fund which is a self-funded and self administered workers’ compensation program.

The Statewide insurance Fund seeks to engage a contractor to provide WC managed care services that can meet the following objectives:

- Support for an effective relationship between the SIF and the contractor ensuring appropriate and high quality medical care for injured employees of member participants in SIF.
- Easy claimant geographic access to needed medical care including, but not limited to emergency, surgical, primary, pharmacy and in-patient care.
- Demonstrated savings based on a contracted network with discounted rates.
- An effective medical management program that assures claimants appropriate and needed medical care while minimizing unnecessary and ineffective service utilization.

It is the intent of the SIF to award a contract to that reasonable bidder whose bid proposal, conforming to this RFP is most advantageous to the SIF, price and other factors considered. However, the SIF reserves the right to separately procure individual requirements that are the subject of the contract during the contract term, when deemed by the Executive Committee and/or Administrator to be in the SIF’s best interest.

Background

The SIF is authorized pursuant to New Jersey Statues Title 40 A and the laws and regulations governing joint insurance fund to self insure for workers’ compensation claims. The SIF has been self insured for workers’ compensation claims since April 1, 1994. SIF contracts independently for workers’ compensation claim administration services. The SIF and its contracted TPA perform the following functions:

- Provides primary program administration and oversight
- Determines compensability
- Manages disability and lost time payments
- Manages litigation
- Interfaces with return to work program
- Participation in safety committee meetings
The Managed Care Organization (MCO) complements and supports the SIF and its TPA through providing the following:

- A contracted provider network with discounts or service fees.
- Medical claim management including protocol-based utilization review.
- An interface with medical care providers on claimant return-to-work program components.
- Repricing, adjudication and payment of provider bills.
- Electronic access of the SIF and the contracted TPA to all provider maintained, employee claimant medical records, file notes and any other pertinent records.
- Electronic reporting of all claims to State agencies and TPA.

**Electronic Question and Answer Period**

The SIF will accept questions and inquiries from all potential proposers electronically. To submit a question, please e-mail the administrator, Caroline Conboy at cconboy@bbmetro.com. Questions should be tied directly to the RFP. The cut off date for electronic questions and inquiries relating to the RFP is indicated on the cover sheet.

**Submission of Bid Proposal**

In order to be considered for award, the proposal must be received by the Administrator’s office of the SIF at the appropriate location and at the appropriate time. Any Bid Proposal not received on time at the location indicated below will be rejected. The date and time is indicated on the cover sheet. The location is as follows:

The Statewide Insurance Fund  
c/o Caroline Conboy  
30 A Vreeland Road  
Florham Park, NJ 07932

**Additional information**

**Addenda: Revisions to this RFP**

In the event that it becomes necessary to clarify or revise this RFP, such clarification or revision will be by addendum. Any addendum to this RFP will become part of this RFP and party of any contract awarded as a result of the RFP.

**Bidder Responsibility**

The bidder assumes sole responsibility for the complete effort required in submitting a proposal is response to this RFP. No special consideration will be given after proposals are opened because of a bidder’s failure to be knowledgeable as to all of the requirements of this RFP.
Cost Liability

The SIF assumes no responsibility and bears no liability for costs incurred by a bidder in the preparation and submittal of a bid proposal in response to this RFP.

Contents of Bid Proposal

Subsequent to bid opening, all information submitted by bidders in response to this RFP is considered public information, except as may be exempted from public disclosure by the Open Public Meetings Act: N.J.S.A. 47:1A-1 et seq. and the common law. Because SIF proposes to negotiate and/or pursue the best and final offer, bid proposals will not be made public until the Letter of intent to award is issued.

A bidder may designate specific information as not subject to disclosure when the bidder has a good faith/legal basis for such assertion. The SIF reserves the right to make the determination and will advise the bidder accordingly. The SIF will not honor any attempt by the bidder either to designate its entire bid proposal as proprietary and/or to claim copyright protection for its entire proposal.

All bid proposals, with the exception of information determined by the SIF or the Court to be proprietary, are available for public inspection after the Letter of Intent to Award is issued. At such time, interested parties can make an appointment with the Administrator to inspect bid proposals received in response to this RFP.

Bid Opening

On the date and time bid proposals are due under the RFP, only the names of the bidders submitting bid proposals will be publicly announced. The contents of the bid proposals shall remain confidential until the Notice of Intent to Award is issued by the SIF.

Price Alternation

Bid prices must be typed. Any price change (including "whiteouts") must be initialed. Failure to initial price changes shall preclude a contract award from being made to the bidder.

Bid Errors

In accordance with N.J.A.C. 17:12-1.22, “Bid Errors”, a bidder may withdraw its bid as follows:

A bidder may request that its bid be withdrawn prior to the bid opening. Such request must be made in writing to the Administrator of the SIF. If the request is granted, the bidder may submit a revised bid as long as the bid is received prior to the announced date and time for bid opening and at the place specified. If after bid opening but before contract award, a bidder discovers an error in its proposal, the bidder may make written request to the Administrator of the SIF for authorization to withdraw its proposal from consideration for award. Evidence of the bidder’s good faith in making this request shall be used in making the determination. The factors that will be considered are that the mistake is so significant that to enforce the contract resulting from the proposal would be
unconscionable; that the mistake relates to a material feature of the contract; that the mistake occurred notwithstanding the bidder’s exercise of reasonable care; and that the SIF will not be significantly prejudiced by granting the withdrawal of the proposal.

All bid withdrawal requests must include the bid title and the final bid opening date and sent to the following address:

Statewide Insurance Fund  
30 A Vreeland Road  
Florham Park, NJ 07932  
Attn: Administrator

If during a bid evaluation process, an obvious pricing error made by a potential contract awardee is found, the Administrator shall issue written notice to the bidder. If the vendor fails to respond, its bid shall be considered withdrawn and no further consideration shall be given it.

If it is discovered that there is an arithmetic disparity between the unit price and the total extended price, the unit price will prevail. If there is any other ambiguity in the pricing other than a disparity between the unit price and extended price and the bidder’s intention is not readily discernible from other parts of the bid proposal, the Administrator may seek clarification from the bidder to ascertain the true intent of the bid.

**Joint Venture**

If a joint venture is submitting a bid proposal, the agreement between the parties relating to such joint venture should be submitted with the joint venture’s bid proposal. Authorized signatories from each party comprising the joint venture must sign the bid proposal. A separate Ownership Disclosure Form, Affirmative Action Employee Information Report and Business Registration or Interim Registration must be supplied for each party to a joint venture.

**General Definitions**

The following definitions will be part of any contract awarded or order placed as a result of this RFP.

**Addendum** – Written clarification or revisions to the RFP issued by the SIF

**All Inclusive Hourly Rate** – An hourly rate comprised of all direct and indirect costs including, but not limited to: overhead, fee or profit, clerical supports, travel expenses, per diem, safety equipment, materials, supplies, managerial support and all documents, forms and reproductions thereof. This rate also includes portal-to-portal expenses as well as per diem expenses such as food.

**Amendment** – A change in the scope of work to be performed by the contractor. An amendment is not effective until it is signed by the Administrator.

**Bidder** – An individual or business entity submitting a bid proposal in response to this RFP.

**Contract** – This RFP, any addendum to this RFP. And the bidder’s proposal submitted in response to this RFP, as accepted by the State.
**Firm Fixed Price** – A price that is all inclusive of direct cost and indirect costs, including, but not limited to, direct labor costs, overhead, fee or profit, clerical supports, equipment, materials, supplies, managerial (administrative) support, all documents, reports, forms, travel, reproduction and any other costs. No additional fees or costs shall be paid by the SIF unless there is a change in the scope of work.

**Joint Venture** – A business undertaking by two or more entities to share risk and responsibility for a specific project.

**May** – Denotes that which is permissible, not mandatory.

**Project** – The undertaking or services that are the subject of this RFP.

**Request for Proposal (RFP)** – This document which establishes the bidding and contract requirements and solicits bid proposals to meet the purchase needs of the SIF as identified herein.

**Shall or Must** – Denotes that which is a mandatory requirement. Failure to meet a mandatory requirement will result in the rejection of a bid proposals as materially non-responsive.

**Should** – Denotes that which is recommended, not mandatory.

**Task** – A discrete unit of work to be performed

**CONTRACT SPECIFIC DEFINITIONS**

**Bill Payment Processing** – Repricing and adjudication and payment of medical bills based on bill payment rules and provider invoices, where paper or electronic.

**Claim** – A single WC case or episode for the entire course of treatment and recovery until the case is either terminated through settlement or the claimant returns to work and is no longer eligible for workers’ compensation benefits. A claim includes medical care, income support and other services and payments as are determined appropriate and compensable under the State workers’ compensation law.

**Claimant** – An individual seeking compensation or services or both for an injury or illness that resulted from workplace activities.

**Contracted Provider Network** – A group of professional, institutional, pharmacy and other health care providers with whom the contractor has formal contractual agreements that specify terms, conditions and rates for providing services to a targeted population and is certified by the Department of Banking and Insurance (DOBI).

**Department of Banking and Insurance (DOBI)** – State agency charged with overseeing and regulating the banking and insurance industries in New Jersey.

**Managed Care Services** – Medical treatment provided through a contracted provider network that follows written treatment and diagnostic protocols and includes external professional oversight and
management of treatment patterns and practices and denial of submitted bills for services unrelated to the compensable injury.

**Medical Only Claim** – A claim that requires only payment for medical services with no income payments for lost time at work or payments for other services and benefits to the claimant.

**Return to Work Program** – A program of established policies, practices and resources for assisting a claimant for workers’ compensation benefits and the claimant’s physician in returning the claimant to work, including limited or light duty work, after a work related injury.

**SCOPE OF WORK**

The contractor shall provide workers’ compensation (WC) managed care services to members’ employees of the SIF receiving benefits compensable under the SIF’s workers’ compensation program and applicable laws and regulations.

Further, the contractor shall ensure a network of providers that is certified by the DOBI in accordance with the applicable laws and regulations, through the term of the contract.

At a minimum the contractor shall provide a program that includes:

- Contracted DOBI certified provider network access for all compensable medical claims.
- Medical management of claims including a provider program to support claimant return to work
- Medical Bill repricing, processing and payment.
- Electronic interface with SIF and TPA for all reporting and payments.

**General**

The contractor shall:

1. Provide documentation that the Managed Care Organization has been certified in the State of New Jersey by DOBI.
2. Ensure capacity to provide managed care services for all SIF WC claims.
3. Provided managed care services for all claims incurred on and after the effective date of this contract and all open or re-opened claims held by the previous MCO including, but not limited to, claimants who require continuing medical treatment as a result of being judged 100% permanently disabled by a Judge of Workers’ Compensation. The current population of “takeover” claims total approximately 91.
4. Provide the SIF direct access to a representative who will be available for consultation through phone call, e-mail and attendance at various meetings off site at the request of the SIF or the Administrator.
5. Provide a 1-800 number during off business hours (Monday through Friday between 5:00 pm through 8 am eastern time and weekend between 5:00 pm Friday through 8 am Monday to direct employees to an appropriate network provider if care is needed.
TPA AND SIF INTERFACE

The SIF contracts with a Third Party Claims administrator for the purpose of claim management and payment of medical and indemnity claims. The contractor shall:

1. provide and maintain an electronic interface with the SIF and the SIF TPA including upload and download facilities between the contractor’s systems and the SIF and SIF TPA system.
   Contact TPA: Wayne Dietz and D & H Risk Solutions – 973-940-1851 for detailed information on data system interface.

2. provide electronic reporting on all provider claims. The contractor, at a minimum, the following reports:
   a. Total medical payments (by calendar month and loss date by month)
   b. Total medical payments by member (by calendar month and by loss date by month)
   c. Medical bill cost savings (by month/year by calendar year and by accident year)
   d. Hospital Savings (by month/year by calendar year and by accident year)
   e. Anticipated Medical cost reserving information on all claims on a quarterly basis on the last date of the quarter.
   f. Provide SIF and SIF TPA with real time, pass work protected electronic access to the managed care treatment plan and claim file notes.
   g. Provide SIF and SIF TPA with real time; pass work protected access to it system for reviewing medical reports, diagnostic reports and other related documents on the SIF workers’ compensation claim being handled by the contractor. The access can be provided by a secure internet web browser solution or a secure dedicated line client/server solution.
   h. Provide SIF and SIF TPA with real time, pass work protected electronic access to all SIF claimant medical records, including but not limited to:
      ii. physician narrative reports
      iii. physician office notes
      iv. hospital treatment records
      v. operative reports
      vi. anesthesiology/pain management reports
      vii. diagnostic studies including but not limited to
      aa. x-ray reports
      bb. MRI results
      cc. EMG results
      dd. EKG results
      ee. CAT results
      viii. physiotherapy notes, psychiatric/psychological records, and any notes of the individual, assigned by the contractor, reasonable for authorizing treatment, determining reasonableness of the treatment, frequency of the treatment, etc.
   i. Members of the SIF will utilize the 1-800 for the reporting of claims. Contractor will obtain all necessary information for the first report of injury and process initial report and subsequent reports to the regulatory authorities in accordance with the laws and regulations.
   j. For purposes of payments of vendor and provider payments, contractor shall transmit to SIF TPA, on a weekly basis a file requesting payment for the paying of the medical obligations associated with the SIF members.
   k. Transmit invoice through a secure electronic interface.
I. Modify and maintain its system, at the sole cost and expense, to meet the SIF data processing requirements.

PHARMACY PROGRAM

The contractor will provide a pharmacy program to develop a formulary and efficient method of payment of SIF member employee’s pharmacy claims. The contractor shall develop and implement a pharmacy management program that address such issues as prescription patterns and the use of cost effective therapeutically equivalent medications.

PROVIDER NETWORKS

The Contractor will provide a DOBI certified Statewide network of primary care providers that include providers that can supply the full scope of medical care needed for the SIF WC program. The contractor shall ensure that its network of providers is certified by the DOBI in accordance with the law and regulations of New Jersey through the term of the contract.

The contractor shall have provider agreements that ensure there is no balance billing of claimants for the service provided.

The SIF shall have the advantage of network discount on all claim regardless of whether the contractor handles or the SIF TPA handles the claim.

HEALTH CARE MANAGEMENT SERVICES

The contractor shall provide a program for working with network providers on a claimant’s return to work as defined by the member’s individual policy or procedures regarding return to work.

1-800 NUMBER

The contractor shall provide a 1-800 number 24/7, monitored during off hours by a representative who can direct employees to an appropriate network provider if care is needed. The contractor shall submit all claims entered into the WC system by 12 pm the following business day. SIF and SIF TPA will determine final compensability of the claim. If the SIF or SIF TPA determines the claim does not qualify for WC, the contractor shall surrender the claim back to the SIF TPA and will not authorize or direct any further medical treatment.

HIPPA AND BBA COMPLIANCE

The contractor shall, at all times, in performance of this contract, ensure that it maintains compliance with the Health Insurance Portability and Accountability Act (HIPPA) of 1996 and the Balanced Budget Act (BBA) of 1997 governing the protection of patient information.

Such regulatory compliance shall include the erasure and deletion of all personal, confidential information that may be contained on all personal computers and their drives prior to the disposal, or any other disposition that may be required, of such informational technology equipment as per requirements set forth by the US Department of Defense.
BID PROPOSAL PREPARATION AND SUBMISSION

General

The bidder is advised to thoroughly read and follow all instructions contained in this RFP, including the instructions on the RFP’s signatory page, in preparing and submitting its bid proposal.

BID PROPOSAL DELIVERY AND IDENTIFICATION

In order to be considered, a bid proposal must arrive at the SIF Administrator’s office in accordance with the instructions in the RFP. Bidders are cautioned to allow adequate delivery time to ensure timely delivery of bid proposals. State regulation mandates that late bid proposals are ineligible for consideration. **THE EXTERIOR OF ALL BID PROPOSAL PACKAGES ARE TO BE LABELED WITH THE BID IDENTIFICATION AND THE FINAL BID OPENING DATE OR RISK NOT BEING RECEIVED ON TIME.**

NUMBER OF BID PROPOSAL COPIES

The bidder must submit **one (1) full and complete ORIGINAL bid proposal**, clearly marked as the “Original” bid proposal. The bidder should submit 3 full and complete and exact copies of the original. A bidder failing to provide the requested number of copies will be charged the cost incurred by the SIF in reproducing the requested number of copies. It is suggested that the bidder make and retain a copy of its bid proposal.

FORMS THAT MUST BE SUBMITTED WITH BID PROPOSAL

Signatory Page

The bidder shall complete and sign the Signatory page provided in the RFQ. The Signatory page shall be signed by an authorized representative of the bidder. If the bidder is a limited partnership, the Signatory page must be signed by a general partner. If the bidder is a joint venture, the Signatory page must be signed by a principal of each party to the joint venture. Failure to comply will result in rejection of bid proposal.

OWNERSHIP DISCLOSURE FORM

In the event the bidder is a corporation, partnership or sole proprietorship, the bidder must complete the attached Ownership Disclosure Form. A current completed Ownership Disclosure Form must be received prior to or accompany the bid proposal. Failure to do so will preclude the award of a contract.

DISCLOSURE OF INVESTIGATIONS/ACTIONS INVOLVING BIDDER

The bidder shall provide a detailed description of any investigation, litigation, including administrative complaints or other administrative proceedings, involving any public sector clients during the past five years including the nature and status of the investigation, and, for any litigation, the caption of the action, a brief description of the action the date of inception, current status, and, if applicable, disposition.

PROOF OF REGISTRATION THAT MUST BE SUBMITTED WITH THE BID PROPOSAL
**Business Registration Certificate from the Division of Revenue**

Failure to submit a copy of the bidder’s business registration certificate from the Division of Revenue with the Bid proposal will be cause for rejection of the bid proposal.

**Affirmative Action**

The bidder is required to submit a copy of the Certificate of Employee Information or a copy of Federal Letter of Approval verifying that the bidder is operating under a federally approved or sanctioned Affirmative Action program. If the bidder has neither document of Affirmative Action evidence, then the bidder must complete the attached Affirmative Action Employee Information Report. This requirement is a precondition to entering into a contract.

**Non-Collusion Affidavit**

The bidder is required to complete and sign the attached non-collusion affidavit. Failure to submit the Non-Collusion Affidavit will be cause for rejection of the bid.

**TECHNICAL PROPOSAL**

In this section, the bidder shall describe its approach and plans for accomplishing the work as outlined in the RFP. The bidder must set forth its understanding of the requirements of the RFP and its ability to successfully complete the contract. This Section of the bid proposal should contain at least the following information:

**Management Overview**

The bidder shall set forth its overall technical approach and plans to meet the requirements of the RFP in a narrative format. Mere reiterations of RFP tasks and subtasks are strongly discouraged, as they do not provide insight into the bidder’s ability to complete the contract. The narrative should convince the SIF that the bidder’s general approach and detailed plans to undertake and complete the contract are appropriate, realistic and obtainable for the task and subtasks involved.

The bidder’s response should specifically address the following:

**General**

1. Describe the bidder’s philosophy for the delivery of worker’s compensation managed care services.
2. How the bidder’s managed care system will produce savings and how those savings will be calculated and reported to the SIF and SIF TPA. Savings may include network discounts, more effective treatment practices, and earlier return to work, among other areas. Bidder should indicate how the SIF will be able to validate reporting savings such as comparing baseline information. Provide examples of savings reports.
3. How the bidder will manage its relationship with the SIF and the SIF TPA. Describe the organizational structure and management reporting lines that will be in place to manage this contract and respond to inquires and needs from the SIF.
4. The methodology and costs involved with the transition of the current contractor case management program to the bidder.

Interface with SIF and SIF TPA

5. How the bidder’s program will provide SIF access to treatment and claim records, medical reports, diagnostic reports and other related information.
6. Number of months the bidder’s on-line case data is available to SIF.
7. The format, content, data elements and communications method for reporting caseload activity, including open/closed cases, claim aging, and other recommended performance reports.
8. Capabilities for transferring all network provider bills to SIF TPA for payment.
9. Capabilities to process claimant’s first report of injury and subsequent reports as required.
10. Details of user related features of any electronic interface provided for SIF including design, graphical interface and key functions. Attach screenshots as appropriate.
11. Security practices including:
   a. Audit trails such as the ability to log authorized and rejected transactions and the ability to perform reconciliation processing and reporting.
   b. Authorization procedures such as the ability to establish, validate and authorize secure outgoing and incoming transaction connections.
   c. Disaster Recovery Plans.

Pharmacy Program

12. Directory of contracted pharmacy locations in New Jersey including address, city and zip code. The directory should include all pharmacy locations, including those contracted through arrangements with third party pharmacy network vendors.
13. Description of third-party prescription card benefits and the proposed workflow for distributing these cards to injured employees.
14. Description of third-party vendor relationships.
15. Payment methods used for pharmacy network providers. Specify whether the pharmacy contracts incorporate discount rates in relation to the published Average Wholesale Price (AWP) or what other method has been used to establish rates.
16. Specific provisions in the provider agreements that assure no claimant balance billing and include a copy of the standard agreement.
17. The level of savings expected from using the pharmacy network and the calculations and baseline data used to estimate these savings, including consideration of comparisons to historical date and comparable populations.
18. A description of any pharmacy utilization or management programs including specialty pharmacy that addresses such issues as appropriateness, prescription patterns and the use of cost-effective therapeutically equivalent medications.
Provider Network

19. An electronic copy of the current provider directory for New Jersey including the provider’s name, practice specialty, address and zip code.

20. Frequency of directory updates and methods to ensure that the network directly is up-to-date (excludes retired, deceased, terminated, etc. providers).

21. Number of provider locations in the network for 2008, 2009, 2010 and through September 2011. Explain any significant changes 10+/- shrinkage, growth or turnover in the network during the last three years. Describe any plans to change the network composition or size.

22. How the provider contracting program assures the availability of a network primary care provider with the understanding of WC regulations and practice.

23. The provider credentialing and review process used for accepting providers into the network. Provide a copy of the guidelines used for each type and include consideration of the following:

   a. License verification
   b. Accreditation checks
   c. Litigation history
   d. On-site reviews
   e. Primary versus secondary source verification
   f. Recredentialing

24. Criteria and procedures for referral to network specialists.

25. Copies of standard professional and institutional provider agreements and a description of provider agreement provisions, by provider type as applicable, that address:

   a. Claim (bill) submission procedures
   b. Patient Balance billing
   c. Utilization review
   d. Pre-Authorization
   e. Claim (bill) denials
   f. Specialist and diagnostic referral authorizations
   g. Quality Assurance
   h. Reporting on litigation and malpractice
   i. Agreement termination
   j. Submission of initial reports of injury
   k. Other issues that may add value to your proposed work

26. Provider agreement provisions that assure network primary care providers submit a treatment plan to the contractor within 24 hours of claimant contact.

27. The bidder shall complete the following matrix as it relates to the payment methodologies for contracted providers in the bidder’s network by provider type. Indicate the percentage of providers by category in each box and the total number of providers by category in last column on the right. Some providers may be contracted for more than one type of payment methodology. See attached sheet

28. For each provider type, the expected savings compared to the billed charges from the provider agreements.

29. Programs, in addition to credentialing, for evaluating the service quality of network providers.
30. Provider education programs including such areas as continuing education, site visits and newsletters.
31. Peer review program for evaluating the quality of care at hospitals or other healthcare facilities.

Health Care Management Services

32. The days and hours of operation, including telephone access, for the health case management program. Include a description of whether and how the program can meet urgent case management needs after regular business hours.
33. The make-up and structure of the health care management program including staffing and caseload levels, staff qualifications and average length of professional experience by area, if applicable (e.g. pre-certification, concurrent review, case management)
34. Listing of nurse case managers and number of years of employment with contractor and number of years working in managed care field.
35. Health Care management program practices, including:
   a. Procedures for pre-certification length approvals and denials.
   c. Procedures for tracking inpatient and outpatient treatment of evaluate and facilitate care according to treatment plan and utilization protocols.
   d. Any special procedures for managing mental health care.
   e. Level of automation for medical review and use of software tools.
36. The guidelines and protocols used for medical case management, including:
   a. Guidelines and protocols used to determine appropriate medical treatment and lengths of stay.
   b. Guidelines and protocols used to determine appropriate mental health treatment and lengths of stay.
   c. The extent of use of in-house developed guidelines and protocols.
37. The criteria for referral for physician review, the number and percentage of unique cases that have required physician review for each of the last three years.
38. How the program manages diagnosis creep and incidental or secondarily diagnosed problems not directly related to the compensable injury or illness.
39. The program for concurrent, on site treatment reviews, including the percentage of inpatient cases that receive such review.
40. How the health care management unit coordinates with the bill processing unit. Include:
   a. Compensability verification
   b. Pre-certification approvals
   c. Communication methods such as electronic flags, notes, e-mail, etc.

Return to Work

41. The return to work program structure, staffing and approach
42. The use of performance standards for the program
43. The approach for measuring return to work outcomes
44. Practices that support claimant return to light duty.
45. Any special program features
Bill Processing

46. The organization, structure and staffing of the bill processing unit. Include:
   a. Use of production quotas.
   b. Whether the staff will be specifically dedicated to the SIF Program
   c. Historical staff turnover rates for the unit.

47. Audit procedures for measuring payment accuracy. Include:
   a. The percent of bills audited
   b. Procedures for bill audit selection.
   c. Procedures for checking bill review accuracy prior to payment
   d. Procedures for retrospective review of bill payments.

48. Historical financial and procedural medical bill error rates and target error rates.

49. Bill checking and payment controls, included procedure for detecting duplicate billings,
   overcharges, medically unnecessary care and fraud and abuse.

50. The location of the claim processing facility.

**ORGANIZATIONAL SUPPORT AND EXPERIENCE**

The bidder should include information relating to its organization, personnel, and experience, including
but not limited to references, together with contact names and telephone numbers, evidencing the
bidder’s qualifications and capabilities to perform the services required by this RFP.

**ORGANIZATION CHART**

The bidder should include a contract organization chart, with names showing management,
supervisory and other key personnel (including sub-vendor’s personnel). The chart should include the
labor category and title of each such individual. Identify on the chart those individuals who would have
a direct relationship with the SIF should the contract be awarded to the contractor.

**RESUMES**

Detailed resumes should be submitted for all management, supervisory and key personnel to be
assigned to the contract. Resumes should be structured to emphasize relevant qualifications and
experience of these individuals in successfully completing contracts of similar size and scope to those
required by the RFP.

**EXPERIENCE OF BIDDER ON CONTRACTS OF SIMILAR SIZE AND SCOPE**

The bidder should provide a comprehensive listing of contracts of similar size and scope that is has
successfully completed, as evidence of the bidder’s ability to successfully complete the services
requires of this RFP. For each contract, the bidder should provide two names and telephone numbers
of individuals for the other contract party. Beginning and ending dates should also be given for each
contract.

Describe any similar size contract that has been non-renewed or terminated in the last five years.
Provide reasons for non-renewal or termination if known.
FINANCIAL CAPABILITY OF THE BIDDER

In order to provide SIF with the ability to judge the bidder’s financial capacity and capabilities to undertake and successfully complete the contract, the bidder should submit certified financial statements to include a balance sheet, income statement, and statement of cash flow, and all applicable notes for the most recent calendar year or the bidder's most recent fiscal year. If certified financial statements are not available, the bidder should provide either a reviewed or compiled statement from an independent accountant setting forth the same information required for the certified financial statements, together with a certification from the CEO and the CFO, that the financial statements and other information included in the statements fairly present in all material respects the financial condition, results of the operations and cash flows of the bidder as of, and for, the periods presented in the statements. In addition the bidder should submit a bank reference.

If the information is not submitted with the bid proposal, the SIF may still require the bidder to submit it. If the bidder fails to comply with the request within seven (7) business days, the SIF may deem the proposal non-responsive.

A bidder may designate specific financial information as not subject to disclosure when the bidder has a good faith legal/factual basis for such assertion. Bidder may submit specific financial statements in a separate, sealed package clearly marked “Confidential-Financial Information” along with the bid proposal.

The SIF reserves the right to make the determination to accept the assertion and shall so advise the bidder.

SPECIAL CONTRACTUAL TERMS AND CONDITIONS

Precedence of Special Contractual Terms and Conditions

The contract awarded as a result of this RFP shall consist of this RFP, addendum to this RFP, the contractor’s bid proposal and the Notice of Award.

In the event of a conflict between the provisions of this RFP including the Special Contractual Terms and Conditions and any Addendum to this RFP, the Addendum shall govern.

In the event of a conflict between the provisions of this RFP, including any Addendum to this RFP. And the bidder’s bid proposal, the RFP and/or the Addendum shall govern.

Contract Term and Extension Option

The term of the contract shall be for a period of one (1) year. The anticipated “Contract Effective Date” is January 1, 2012. If delays in the bid process result in an adjustment of the anticipated Contract Effective Date, the bidder agrees to accept a contract for the pro-rated term. The Fund will also consider proposals for the 2013 and 2014 fund years. The Fund reserves the right to extend this appointment for two additional one year terms.

Should the contract be extended, the contractor shall be paid at the rates in effect in the last year of the contract.
Contract Transition

In the event a new contract has not been awarded prior to the contract expiration date, as may be extended herein, it shall be incumbent upon the contractor to continue the contract under the same terms and conditions until a new contract can be totally operational. At no time shall this transition period extend more than 180 days beyond the expiration date of the contract.

Contract Amendment

Any changes or modifications to the terms of the contract shall be valid only when they have been reduced to writing and signed by the contractor and the SIF.

Contractor Responsibilities

The contractor shall have sole responsibility for the complete effort specified in the contract. Payment will be made only to the contractor.

The contractor is responsible for the professional quality, technical accuracy and timely completion and submission of all deliverables, services or commodities required to be provided under the contract. The contractor shall, without additional compensation, correct or revise any errors, omissions, or other deficiencies in its deliverables and other services. The approval of deliverables furnished under this contract shall not in any way relieve the contractor of responsibility for the technical adequacy of its work. The review, approval, acceptance or payment for any of the services shall not be construed as a waiver of rights that the SIF may have arising out of the contractor's performance of this contract.

Substitution of Staff

It is becomes necessary for the contractor to substitute any management, supervisory or key personnel, the contractor will identify the substitute personnel and the work performed.

The contractor must provide detailed justification documenting the necessity for the substitution. Resumes must be submitted evidencing that the individual(s) proposed as substitution(s) have qualifications and experience equal to or better than the individual(s) originally proposed or currently assigned.

The contractor shall forward a request to substitute staff to the SIF Administrator for consideration and approval. No substitute personnel are authorized to begin work until the contractor has received written approval to proceed from the SIF Administrator.

OWNERSHIP OF MATERIAL

All data, technical information, materials gathered, originated, developed, prepared, used or obtained in the performance of the contract, including but not limited to, all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video and/or audio), pictures, drawings, analyses, graphic presentations, software computer programs and accompanying documentation and print-outs, notes and memoranda, written procedures and documents, regardless of the SIF’s completion, which are prepared for or are a result of the services required under this contract shall be and remain the property of the Statewide Insurance Fund and shall be delivered to the SIF upon 30 days notice from the SIF. With respect to the software computer programs and/or source codes developed for SIF, the
work shall be considered “work for hire”, i.e., the SIF, not the contractor shall have full and complete ownership of all software computer programs and/or source codes developed. To the extent that any such materials may not, by operation of the law, be a work made for hire in accordance with the terms of this Agreement, contractor or subcontractor hereby assigns to the SIF all right, title and interest in and to any such material, and the SIF shall have the right to obtain and hold in its own name and copyrights, registrations and any other proprietary rights that may be available.

Should the bidder anticipate bringing pre-existing intellectual property into the project, the intellectual property must be identified in the bid proposal. Otherwise, the language in the first paragraph of this section prevails. If the bidder identifies such intellectual property (“Background IP”) in its bid proposal, then the Background IP owned by the bidder on the date of the contract, as well as any modifications or adaptations thereto, remain the property of the bidder. Upon contract award, the bidder or contractor shall grant the SIF a non-exclusive perpetual royalty free license to use any of the bidder/contractor’s Background IP delivered to the SIF for the purposes contemplated by the contract.

**Data Confidentiality**

All financial, statistical, personnel and/or technical data supplied by SIF to the contractor are confidential. The contractor is required to use reasonable care to protect the confidentiality of such data. Any use, sale or offering of this data in any form by the contractor, or any individual or entity in the contractor’s charge or employ, will be considered a violation of this contract and may results in contract termination and the contractor’s suspension. In addition, such conduct may be reported to the State Attorney General for possible criminal prosecution.

**News Releases**

The contractor is not permitted to issue news releases pertaining to any aspect of the services being provided under this contract without the prior written consent of the SIF.

**Advertising**

The contractor shall not use the SIF name, logos, images or any data or results arising from this contract as a part of any commercial advertising without first obtaining the prior written consent of the SIF.

**License and Permits**

The contractor shall obtain and maintain in full force and effect all required licenses, permits, and authorizations necessary to perform this contract. The contractor shall supply the SIF Administrator will all evidence of all such licenses, permits and authorizations. This evidence shall be submitted subsequent to the contract award. All costs associated with any such license, permits and authorizations must be considered by the bidder in its bid proposal.

**CLAIMS AND REMEDIES**

**Claims**

All claims asserted against the SIF by the contractor shall be subject to the New Jersey Tort Claims Act., N.J.S.A. 59-1, et seq., and/or the New Jersey Contractual Liability Act, N.J.S.A. 59:13-1, et seq.
Remedies

Nothing in the contract shall be construed to be a waiver by the SIF of any warranty, expressed or implied, of any remedy at law or equity, except as specifically and expressly stated in a writing executed by the SIF.

Remedies For Failure to Comply with Material Contract Requirements

In the event that the contractor fails to comply with any material contract requirements, the SIF Administrator may take steps to terminate the contract and/or authorize the delivery of contract items by any available means, with the difference between the price paid and the defaulting contractor’s price either being deducted from any monies due the defaulting contractor or being an obligation owed to the SIF by the defaulting contractor.

SIF’S OPTION TO REDUCE SCOPE OF WORK

The SIF has the option, at its sole discretion, to reduce the scope of work for any tasks or subtask called for under this contract. In such an event, the SIF Administrator shall provide advance written notice to the contractor.

Upon receipt of such written notice, the contractor shall submit within five (5) working date to the SIF Administrator, an itemization of the work effort already completed by task or subtask. The contractor shall be compensated for such work effort according to the applicable portions of its price schedule.

CHANGE IN LAW

Whenever an unforeseen change in applicable law or regulation affects the services that are the subject of this contract, the contractor shall advise the SIF Administrator in writing and include in such written transmittal any estimated increase or decrease in the cost of the performance of services as a result of such change in law or regulation. The Administrator and the contractor shall negotiate an equitable adjustment, if any, to the contracted price.

FORM OF COMPENSATION AND PAYMENT

The method of compensation will be based on the proposal accepted by the SIF.

PATENT AND COPYRIGHT INDEMNITY

A. The Contractor shall hold and save the SIF, its officers, agents, servants and employees harmless from liability of any nature or kind for or on account of the use of any copyrighted or uncopyrighted composition, secret process, patented or unpatented invention, article or appliance, furnished or used in the performance of the contract.

B. The SIF agrees (1) to promptly notify the Contractor in writing of such claim or suit; (2) that the Contractor shall have control of the defense of such settlement of such claim or suit; and (3) to cooperate with the Contractor in the defense of such claim or suit.

C. In the event of such claim or suit, the Contractor, at its option, may: (1) procure for the SIF the legal right to continue the use of the product; (2) replace or modify the product
to provide a non-infringing product that is the functional equivalent; or (3) refund the purchase price less a reasonable allowance for use that is agreed to by both parties.

**INDEMNIFICATION**

The Contractor shall indemnify and hold the SIF, its Commissioners and appointed officials and local units harmless from any and all claims or liabilities arising out of the activities of the Contractor, its employees, agents and subcontractors in connection with all activities undertaken by the contractor, pursuant to this RFP and subsequent agreement. It is the intention of the parties that any claim for relief of any type being asserted against the Fund, its commissioners, appointed officials and member local units, based upon any act or omission of the Contractor, its affiliates and successors, shall be the responsibility of the Contractor, and the Contractor shall hold the Fund, its commissioners, appointed officials and member local units harmless from same.

**INSURANCE**

The Contractor agrees to provide the following insurance coverage throughout the entire duration of the agreement:

A. Workers’ Compensation: Statutory Benefits in accordance with the Compensation Laws of the State of New Jersey.

B. Employer’s Liability Limit: $1,000,000

C. General Liability – Minimum Limit of Liability:
   - Bodily Injury and Property Damage Liability Each Occurrence: $2,000,000
   - General Aggregate: $2,000,000
   - Products and Completed Operations: $2,000,000
   - Personal and Advertising Injury: $2,000,000
   - Fire Damage (any one fire): $50,000
   - Medical Expense (any one person): $5,000

D. Automobile Liability – Minimum Limit of Liability:
   - Bodily Injury and Property Damage Liability Combined Single Limit: $2,000,000
   - Uninsured/Underinsured Motorist Liability: $2,000,000
   - Hired and Non-Owned Liability: $2,000,000

E. Errors and Omissions – Minimum Limit of Liability:
   - $1,000,000 each claim/annual aggregate
F. Performance Bond: Full Value of the Agreement

Insurance Coverage must be provided by a carrier authorized to transact business in the State of New Jersey and has an A- or better rating as established by A.M. Best and Company.

Proof of the above coverages shall be provided to the Administrator’s office within thirty (30) days of the date of the signing of the contract and in the event the Contractor fails to supply required proof of insurance within thirty (30) days receipt of written notice of deficiency, the Fund may terminate the contract immediately upon retention of a replacement of managed care services.

ORAL PRESENTATION AND/OR CLARIFICATION OF BID PROPOSAL

After the submission of bid proposals, unless requested by the SIF, contractor contact with the SIF is not permitted.

A bidder may be required to give an oral presentation to the Executive Committee concerning its Bid Proposal. The Executive Committee may also require a bidder to submit written responses to questions regarding its bid proposal.

The purpose of such communication with the bidder, either through an oral presentation of a letter of clarification, is to provide an opportunity for the bidder to clarify or elaborate on its bid proposal. Original bid proposals submitted, however, cannot be supplemented, changed or corrected in any way. No comments regarding other bid proposal are permitted. Bidders may not attend presentations made by their competitors.

It is within the Executive Committee or Administrator’s discretion whether to require a bidder to give an oral presentation or require a bidder to submit written responses to questions regarding its bid proposal. Action by the Executive Committee or Administrator in this regard should not be construed to imply acceptance or rejection of a bid proposal.

EVALUATION CRITERIA

The following evaluation criteria categories, not necessarily listed in order of significance, will be used to evaluate bid proposals received in response to this RFP. The evaluation criteria categories may be used to develop more detailed evaluation criteria to be used in the evaluation process:

Technical Evaluation Criteria

A) The bidder’s general approach and plans in meeting the requirements of this RFP.

B) The bidder’s detailed approach and plans to perform the services required by the scope of the work of this RFP.

C) The bidder’s documented experience in successfully completing contracts of similar size and scope to the work required by this RFP.

D) The qualifications and experience of the bidder’s management, supervisory or other key personnel assigned to the contract, with emphasis on documented
experience in successfully completing work on contracts of similar size and scope to the work required by this RFP.

E) The overall ability of the bidder to mobilize, undertake and successfully complete the contract. This judgment will include, but not be limited to, the following factors: the number and qualifications of management, supervisory and other staff proposed by the bidder to complete the contract, the availability and commitment to the contract of the bidder’s management, supervisory and other staff proposed and the bidder’s contract management plan, including the bidder’s contract organizational chart.

Bid Discrepancies

In evaluating bids, discrepancies between words and figures will be resolved in favor of words. Discrepancies between unit prices and total of unit prices will be resolved in favor of unit prices. Discrepancies in the multiplication of units of work and unit prices will be resolved in favor of the unit prices. Discrepancies between the indicated total of multiplied unit prices and units of work and the actual total will be resolved in favor of the actual total. Discrepancies between the indicated sum of any column of figures and the correct sum thereof will be resolved in favor of the corrected sum of the column of figures.

Evaluation of the Bid Proposals

The Administrator will complete its evaluation and recommend to the Executive Committee for award the responsible bidder whose bid proposal, conforming to this RFP, is most advantageous to the SIF, prices and other factors considered. The Administrator considers and assesses prices, technical criteria, and other factors during the evaluation process.

NEGOTIATION AND BEST FINAL OFFER (BAFO)

Following the opening of the bid proposals, the SIF, shall negotiate one or more of the following contractual issues: the technical services offered, the terms and conditions and/or price of the proposed contract award with any bidder, and/or solicit a BAFO from one or more bidders.

Initially, the Administrator will conduct a review of all the bids and select bidders to contact to negotiate and/or conduct a BAFO based on its evaluation and determination of the bid proposal that best satisfy the evaluation criteria and RFP requirements, and that are most advantageous to the SIF, price and other factors considered. The Administrator may not contact all bidders to negotiate and/or submit a BAFO.

In response to the SIF’s request to negotiate, bidders must continue to satisfy all mandatory RFP requirements but may improve upon their original technical proposal in any revised technical proposal. However, any revised technical proposal that does not continue to satisfy all mandatory requirements will be rejected as non-responsive and the original technical proposal will be used for any further evaluation purposes in accordance with the following procedure.

In response to the SIF’s request for a BAFO, bidders may submit a revised price proposal that is equal to or lower in price than their original submission, but must continue to satisfy all mandatory
requirements. Any revised price proposal that is higher in price than the original will be rejected as non-responsive and the original bid will be used for any further evaluation purposes.

**CONTRACT AWARD**

**Documents required before contract award**

In order to safeguard the integrity of local government procurement by imposing restrictions to insulate the negotiation and award of local government contracts from political contributions that pose the risk of improper influence, purchase of access, or the appearance thereof, the Legislature enacted N.J.S.A. 19:44A-20.13-25 on March 22, 2005, retroactive to October 15, 2004, superseding the terms of Executive Order 134. Pursuant to the requirements of the Legislation, the terms and conditions set forth in this section are material terms of any contract resulting from this RFP.

**Definitions**

For the purpose of this section, the following shall be defined as follows:


b) Business Entity – means any natural or legal person, business corporation, professional services corporation, Limited Liability Corporation, partnership, limited partnership, business trust, association or any other legal commercial entity organized under the laws of New Jersey or any other state or foreign jurisdiction. The definition of a business entity includes (i) all principals who own or control more than ten (10) percent of the profits or assets of a business entity or ten (10) percent of the stock in the base of a business entity that is a corporation for profit, as appropriate; (ii) any subsidiaries directly or indirectly controlled by the business entity; (iii) any political organization organized under Section 527 of the Internal Revenue Code that is directly or indirectly controlled by the business entity, other than a candidate committee, election fund, or political party committee; and (iv) a business entity is a natural person, that person’s spouse or child, residing in the same household.

**Breach of Terms of the Legislation**

It shall be a breach of the terms of the contract for the Business Entity to (i) make or solicit a contribution in violation of the Legislation, (ii) knowingly conceal or misrepresent a contribution given or received’ (iii) make or solicit contributions through intermediaries for the purpose of concealing or misrepresenting the source of the contribution; (iv) make or solicit any contribution of the condition or with the agreement that it will be contributed to a campaign committee or any candidate or holder of the public officials of Governor, or to any State of County party committee; (v) engage or employ a lobbyist or consultant with the intent or understanding that such lobbyist or consultant would make or solicit any contribution, which if made or solicited by the business entity itself, would subject that entity to the restrictions of the Legislation; (vi) fund contributions made by third parties, including consultants, attorneys, family members, and employees; (vii) engage in any exchange of contributions to
circumvent the intent of the Legislation; or (viii) directly or indirectly through or by any other person or means, do any act which would subject that entity to the restrictions of the Legislation.

Certification and Disclosure Requirements

a) The SIF shall not enter into a contact to procure from any Business Entity services, where the value of the transaction exceeds $17,500. If that Business Entity has solicited or made any contribution of money, or pledge or contribution including in-kind contributions to a candidate committee and/or election fund of any candidate for or holder of the public office of Governor, or to any State, County of local political party committee during certain specified time periods.

b) Prior to awarding any contract or agreement to any Business Entity, the Business Entity proposed as the intended awardee of the contract shall submit the Certification and Disclosure Form with their response to the RFP, certifying that no contributions prohibited by the Legislation have been made by the Business Entity and reporting all contributions to the Business Entity made during the proceeding four years to any political organization organized under 26 U.S.C.527 of the Internal Revenue Code that also meets the definition of a “continuing political committee” within the mean of N.J.S.A. 19:44A-3 (n) and N.J.A.C. 19:25-1.7.

c) Further, the Contractor is required, on a continuing basis, the report any contributions it makes during the term of the contract, and any extension(s) thereof, any such contribution is made.

Additional Disclosure Requirement

Contractor is advised of its responsibility to file an annual disclosure statement on political contributions with the New Jersey Election Law Enforcement Commission (ELEC), pursuant to P.L. 2005, c.271, section 3 if the contractor receives contracts in excess of $50,000 from a public entity in a calendar year. It is the contractor’s responsibility to determine if filing is necessary. Failure to file can result in the imposition of financial penalties by the ELEC.

Additional Comments regarding the RFP

1. Requests for additional information are to be made only to the SIF Administrator, Caroline Conboy, as indicated in the RFQ. Bidder is not to contact the current managed care company, the third party claims administrator, any Executive Committee member or Alternate member, or any one else in the Administrator’s office with regard to this RFP without the written consent of the Administrator.

2. The bidder is permitted to provide different methodologies for pricing the managed care contract and provide a recommendation to the SIF as to which methodology is the most beneficial to the SIF and the reasons for the recommendation.

3. Included with the RFP are sample medical bills. The bidder is to provide an exhibit which shows the medical bill repricing of the bills through the contracts the bidder has in place with facilities/Doctors named on the bill. If the bidder does not have a contact with the facility/doctor, bidder must advise on the exhibit. Bidder is prohibited from using another network facility or contracted third party vendor to reprice the invoice(s).
EXHIBIT A
MANDATORY EQUAL EMPLOYMENT OPPORTUNITY LANGUAGE
N.J.S.A. 10:5-31 et seq. and N.J.A.C. 17:27 et seq.

GOODS, PROFESSIONAL SERVICES AND GENERAL SERVICE CONTRACTS

During the performance of this contract, the contractor agrees as follows:

The contractor or subcontractor, where applicable, will not discriminate against any employee or applicant for employment because of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, or sex. Except with respect to affectional or sexual orientation, the contractor will take affirmative action to ensure that such applicants are recruited and employed, and that employees are treated during employment, without regard to their age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, or sex. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising, layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Public Agency Compliance Officer setting forth provisions of this non-discrimination clause.

The contractor or subcontractor, where applicable will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation or sex.

The contractor or subcontractor, where applicable, will send to each labor union or representative or workers with which it has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer advising the labor union or workers' representative of the contractor's commitments under this act and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

The contractor or subcontractor, where applicable, agrees to comply with any regulations promulgated by the Treasurer pursuant to N.J.S.A. 10:5-31 et seq., as amended and supplemented from time to time and the Americans with Disabilities Act.

The contractor or subcontractor agrees to attempt in good faith to employ minority and female workers consistent with the applicable county employment goals established in accordance with N.J.A.C. 17:27-5.2, or a binding determination of the applicable county employment goals determined by the Division, pursuant to N.J.A.C. 17:27-5.2.

The contractor or subcontractor agrees to inform in writing its appropriate recruitment agencies including, but not limited to, employment agencies, placement bureaus, colleges, universities, labor unions, that it does not discriminate on the basis of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, or sex, and that it will discontinue the use of any recruitment agency which engages in direct or indirect discriminatory practices.

The contractor or subcontractor agrees to revise any of its testing procedures, if necessary, to assure that all personnel testing conforms with the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.

In conforming with applicable employment goals, the contractor or subcontractor agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

The contractor shall submit to the public agency, after notification of award but prior to execution of a goods and services contract, one of the following three documents:

Letter of Federal Affirmative Action Plan Approval
Certificate of Employee Information Report
Employee Information Report Form AA302
The contractor and its subcontractor shall furnish such reports or other documents to the Division of Contract Compliance & EEO as may be requested by the Division from time to time in order to carry out the purposes of these regulations, and public agencies shall furnish such information as may be requested by the Division of Contract Compliance & EEO for conducting a compliance investigation pursuant to Subchapter 10 of the Administrative Code at N.J.A.C. 17:27.
ATTENTION ALL PROFESSIONAL SERVICE ENTITIES

On June 29, 2004, Governor McGreevey signed P.L. 2004, c.57, Business Registration of Contractors with Government Agencies, into law. Effective September 1, 2004, all business organizations that do business with a local contracting agency (i.e. STATEWIDE INSURANCE FUND) are required to be registered with the State of New Jersey, Department of Treasury, Division of Revenue, and provide proof of that registration to the contracting agency before the contracting agency may enter into a contract with the business.

A “Business Organization” means an individual, partnership, association, joint stock company, trust, corporation or other legal business entity or successor thereof.

The law provides that: A copy of the Business Registration Certificate issued by the NJ Department of Treasury, Division of Revenue, shall be provided at the time any submission is received; failure to do so is a fatal defect that cannot be cured. This law covers construction as well as non-construction submissions.

Further information may be obtained by visiting the following web site at the State of New Jersey: www.nj.gov/treasury/revenue/busregcert.htm

Goods & Services Contracts (including purchase orders):

N.J.S.A. 52:32-44 imposes the following requirements on contractors and all subcontractors that knowingly provide
goods or perform services for a contractor fulfilling this contract:

1) The contractor shall provide written notice to its subcontractors and suppliers to submit proof of business registration to the contractor;

2) Prior to receipt of final payment from a contracting agency, a contractor must submit to the contracting agency an accurate list of all subcontractors or attest that none were used;

3) During the term of this contract, the contractor and its affiliates shall collect and remit, and shall notify all subcontractors and their affiliates, that they must collect and remit to the Director, New Jersey Division of Taxation, the use tax due pursuant to the Sales and Use Tax Act, (N.J.S.A. 54:32B-1 et seq.) on all sales of tangible personal property delivered into this State.

A contractor, subcontractor or supplier who fails to provide proof of business registration or provides false business registration information shall be liable to a penalty of $25 for each day of violation, not to exceed $50,000 for each business registration not properly provided or maintained under a contract with a contracting agency.
The CONTRACTOR and the STATEWIDE INSURANCE FUND (herein referred to as “Statewide”) do hereby agree that the provisions of Title 11 of the Americans With Disabilities Act of 1990 (the "Act") (42 U.S.C. §12101 et seg.), which prohibits discrimination on the basis of disability by public entities in all services, programs and activities provided or made available by public entities, and the rules and regulations promulgated pursuant thereunto, are made a part of this contract. In providing any aid, benefit, or service on behalf of the STATEWIDE pursuant to this contract, the CONTRACTOR agrees that the performance shall be in strict compliance with the Act. In the event the CONTRACTOR, its agents, servants, employees, or subcontractors violate or are alleged to have violated the Act during the performance of this contract, the CONTRACTOR shall defend the STATEWIDE in any action or administrative proceeding commenced pursuant to this Act. The CONTRACTOR shall indemnify, protect, and save harmless the STATEWIDE, its agents, servants, and employees from and against any and all suits, claims, losses, demands, or damages of whatever kind or nature arising out of or claimed to arise out of the alleged violation. The CONTRACTOR shall, at its own expense, appear, defend, and pay any and all charges for legal services and any and all costs and other expenses arising from such action or administrative proceeding or incurred in connection therewith. In any and all complaints brought pursuant to the STATEWIDE'S grievance procedure, the CONTRACTOR agrees to abide by any decision of the STATEWIDE, which is rendered pursuant to, said grievance procedure. If any action or administrative proceeding results in an award of damages against the STATEWIDE or if the STATEWIDE incurs any expense to cure a violation of the ADA which has been brought pursuant to its grievance procedure, the CONTRACTOR shall satisfy and discharge the same at its own expense.

The STATEWIDE shall, as soon as practicable after a claim has been made against it, give written notice thereof to the CONTRACTOR along with full and complete particulars of the claim. If any action or administrative proceeding is brought against the STATEWIDE or any of its agents, servants, and employees, the STATEWIDE shall expeditiously forward or have forwarded to the CONTRACTOR every demand, complaint, notice, summons, pleading, or other process received by the STATEWIDE or its representatives.

It is expressly agreed and understood that any approval by the STATEWIDE of the services provided by the CONTRACTOR pursuant to this contract will not relieve the CONTRACTOR of the obligation to comply with the Act and to defend, indemnify, protect, and save harmless the STATEWIDE pursuant to this paragraph.

It is further agreed and understood that the STATEWIDE assumes no obligation to indemnify or save harmless the CONTRACTOR, its agents, servants, employees and subcontractors for any claim which may arise out of their performance of this Agreement. Furthermore, the CONTRACTOR expressly understands and agrees that the provisions of this indemnification clause shall in no way limit the CONTRACTOR’S obligations assumed in this Agreement, nor shall they be construed to relieve the CONTRACTOR from any liability, nor preclude the STATEWIDE from taking any other actions available to it under any other provisions of this Agreement or otherwise at law.
Please Note this Additional Requirement:

Professional services entities shall submit one (1) original and three (3) additional sets of their sealed submission and one CD, no later than 2:00 pm on September 23, 2011. The Fund will not accept proposals that are e-mailed.
STATEWIDE INSURANCE FUND

CHECKLIST

PROFESSIONAL SERVICE TITLE:

SUBMISSION DATE: September 23, 2011 by 2:00 pm

The following items, as indicated below (X), shall be provided with the receipt of sealed submissions:

1. Non-Collusion Affidavit

2. Disclosure of Fund Ownership Form

3. Insurance Requirement Acknowledgement Form

4. Mandatory Equal Employment Opportunity Notice Acknowledgement Form

5. Copy of your Business Registration Certificate as issued by the State of New Jersey, Department of Treasury, Division of Revenue

6. Professional Service Entity Information Form
7. Data Form …………………………………………………………

8. Acknowledgement of Corrections, Additions or Deletions Form……………………………………._________
STATEWIDE INSURANCE FUND

NON-COLLUSION AFFIDAVIT

STATE OF NEW JERSEY:

SS.

COUNTY OF:

I, ______________________________________ of the ________________
of _________________________
in the County of ________________ and the State of New Jersey, of full age,
being duly sworn according to law on my oath depose and say that:

I am ____________________________________________

of the firm of ____________________________________________

the Professional Service Entity making the submission for the above named
Service, and that I executed the said submission with full authority to do so; that
said Professional Service Entity has not, directly or indirectly, entered into any
agreements, participated in any collusion, or otherwise taken any action in
restraint of fair and open competition in connection with the above named
Service; and that all statements contained in said submission and in this affidavit
are true and correct, and made with full knowledge that the STATEWIDE relies
upon the truth of the statements contained in said submission and in the
statements contained in this affidavit in awarding the contract for said Service.

I further warrant that no person or selling agency has been employed or retained
to solicit or secure such contract upon an agreement or understanding for a
commission, percentage, brokerage or contingent fee, except bonafide
employees or bonafide established, commercial or selling agencies maintained
by:

______________________________________________

Name of Professional Service Entity

Subscribed and sworn to before me
this _________ day of ____________, 20___
Notary Public, State of ________________  (Signature of Professional)

My Commission expires___________________

____________________________________
(Type or Print name of affiant and Title, under signature)
STATEWIDE INSURANCE FUND
DISCLOSURE OF FUNDSHIP FORM

N.J.S.A. 52:25-24.2 reads in part that "no corporation or partnership shall be awarded any contract by the State, County, Municipality or School District, or any subsidiary or agency thereof, unless prior to the receipt of the submission of the corporation or partnership, there is provided to the public contracting unit a statement setting forth the names and addresses of all individual who own 10% or more of the stock or interest in the corporation or partnership."

1. If the professional service entity is a *partnership*, then the statement shall set forth the names and addresses of all partners who own a 10% or greater interest in the partnership.

2. If the professional service entity is a *corporation*, then the statement shall set forth the names and addresses of all stockholders in the corporation who own 10% or more of its stock of any class.

3. If a corporation owns all or part of the stock of the corporation or partnership providing the submission, then the statement shall include a list of the stockholders who own 10% or more of the stock of any class of that corporation.

4. If the professional service entity is other than a corporation or partnership, the contractor shall indicate the form of corporate Fundship as listed below.

**COMPLETE ONE OF THE FOLLOWING STATEMENTS:**

1. Stockholders or Partners owning 10% or more of the company providing the submission:
   NAME:                        ADDRESS:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
SIGNATURE: __________________________________________

_________ DATE: ____________________________

II. No Stockholder or Partner owns 10% or more of the company providing this submission:

SIGNATURE: __________________________________________

_________ DATE: ____________________________

III. Submission is being provided by an individual who operates as a sole proprietorship:

SIGNATURE: __________________________________________

_________ DATE: ____________________________

IV. Submission is being provided by a corporation or partnership that operates as a (check one of the following):

   ______ Limited Partnership
   ______ Limited Liability Corporation

   ______ Limited Liability Partnership
   ______ Subchapter S Corporation

SIGNATURE: __________________________________________

DATE: ____________________________
STATEWIDE INSURANCE FUND

INSURANCE REQUIREMENTS AND ACKNOWLEDGEMENT FORM

Certificate(s) of Insurance shall be filed with the Administration Office upon award of contract by the Statewide Insurance Fund Executive Committee.

Acknowledgement of Insurance Requirement:

Dated: ___________________________________________ (Signature)  

__________________________________  
(Printed Name and Title)
STATEWIDE INSURANCE FUND

MANDATORY EQUAL EMPLOYMENT OPPORTUNITY NOTICE
(N.J.S.A. 10:5-31 et seq. and N.J.A.C. 17:27 et seq.)

GOODS, PROFESSIONAL SERVICES AND GENERAL SERVICE CONTRACTS

This form is a summary of the successful professional service entity’s requirement to comply with the requirements of N.J.S.A. 10:5-31 et seq. and N.J.A.C. 17:27 et seq.

The successful professional service entity shall submit to the Statewide Insurance Fund, after notification of award but prior to execution of this contract, one of the following three documents as forms of evidence:

(a) A photocopy of a valid letter that the vendor is operating under an existing Federally approved or sanctioned affirmative action program (good for one year from the date of the letter);

OR

(b) A photocopy of a Certificate of Employee Information Report approval, issued in accordance with N.J.A.C. 17:27-1.1 et seq.;

OR

(c) A photocopy of an Employee Information Report (Form AA302) provided by the Division of Contract Compliance and distributed to the
STATEWIDE to be completed by the vendor in accordance with N.J.A.C. 17:27-1.1 et seq.

The successful professional service entity may obtain the Employee Information Report (AA302) from the Statewide Insurance Fund during normal business hours.

The successful professional service entities must submit the white and canary copies of the AA302 (Employee Information Report) to the Division of Contract Compliance and Equal Employment Opportunity in Public Contracts (Division). The pink Public Agency copy is submitted to the STATEWIDE of Clinton, and the gold Vendor copy is retained by the professional service entity.

The undersigned professional service entity certifies that he/she is aware of the commitment to comply with the requirements of N.J.S.A. 10:5-31 et seq. and N.J.A.C. 17:27 et seq. and agrees to furnish the required forms of evidence.

The undersigned professional service entity further understands that his/her submission shall be rejected as non-responsive if said professional service entity fails to comply with the requirements of N.J.S.A. 10:5-31 et seq. and N.J.A.C. 17:27 et seq.
COMPANY:
___________________________________________
___________________________________________
___________________________________________

SIGNATURE: _________________________
Title _________________________

PRINT NAME: _________________________
Dated: _________________________
STATEWIDE INSURANCE FUND

PROFESSIONAL SERVICE ENTITY INFORMATION FORM

If the Professional Service Entity is an *INDIVIDUAL*, sign name and give the following information:

Name: _____________________________________________________________________________________________________

______________________________________________________________________________________________________________

Address: ___________________________________________________________________________________________________

______________________________________________________________________________________________________________

Telephone No.: ____________________________

Fax No.: _______________________________ E-Mail Address: ____________________________________________________________

If individual has a TRADE NAME, give such trade name:

Trading As: _______________________________________ Telephone No.: _____________________________________________

***************************************************************************************************************************

***************************

If the Professional Service Entity is a *PARTNERSHIP*, give the following information:

Name of Partners: ______________________________________________________________________________________________

Firm Name: ___________________________________________________________________________________________________

Address: ___________________________________________________________________________________________________

Telephone No.: ____________________________ Federal I.D. No.: __________________________________________________________

Fax No.: _______________________________ E-Mail address: ______________________________________________________________

Social Security __________________________________________________________________________________________________

Signature of authorized agent: __________________________________________________________________________________

***************************************************************************************************************************
If the Professional Service Entity is *INCORPORATED*, give the following information:

State under whose laws incorporated: ________________

Location of principal office:
____________________________________________________________________________________
____________________________________________________________________________________
Telephone No.: __________________________ Federal I.D. No.: ________________________________
Fax No.: _______________________________ E-Mail address: ________________________________

Name of agent in charge of said office upon whom notice may be legally served:
____________________________________________________________________________________
____________________________________________________________________________________
Telephone No.: _________________________ Name of Corporation: _____________________________

Signature: ____________________________________________
DATA FORM

(Print or Type)
Name and Address of Servicing Organization

In connection with the above-named company, I hereby make representations and supply information about myself as hereinafter set forth. (attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS “NONE” or “NO EXCEPTION”, SO STATE.

1. Affiant’s Full Name: __________________________________________

2. Other Names Used at any Time: ________________________________

3. Date of Birth: _______________ Place of Birth: __________________

4. Social Security Number: _______________________________________

5. For the last 10 years, I have lived at the following address or addresses:

ADDRESS CITY
DATES
6. Schooling:
   College:
   _____________________________________________
   Graduate:
   _____________________________________________
   or
   Professional:
   _____________________________________________
   Degree (List):

ATTACH LIST OF ALL EDUCATIONAL INSTITUTIONS AND LOCATION-CITY AND STATE)

7. Member Of Professional Societies Or Associations (List):

8. I presently hold or have held, in the past, the following professional, occupational, and vocational licenses issued by public or governmental licensing agencies or authorities
(state date license issue, issuer of license, date terminated, reason for termination):

- 

_______________________________________
_____________________________________
9. Present Chief Occupation:

Position or Title:

Employer’s Name

Address:

How long in this position?_______

How long with this employer?_______

Where?_______

10. Other jobs, positions, directorates or officerships concurrently held at present.

- 

11. Complete Employment record for Past 20 Years:

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<th>DATES</th>
<th>EMPLOYER AND ADDRESS</th>
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<tr>
<td>TITLE</td>
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(attach further history if necessary)

12. I control directly or indirectly or own legally or beneficially 10% or more of the outstanding capital stock (in voting power) of the following companies:

- 

12a. If any of the above stock is pledged or hypothecated in any way, please detail fully:

- 

13. I have never been adjudicated as bankrupt, except as follows:
14. I have never been convicted or had a sentence imposed or suspended, or had pronouncement of a sentence suspended, or been pardoned for conviction of, or pleaded guilty of an nolo contendere to an information an indictment charging a felony for embezzlement, theft or larceny, mail fraud, or violating any corporate securities statute or any insurance law, nor have I been the subject of a cease and desist order or consent order of any federal or state regulatory agency, except as follows:

15. During the last 10 years, I have neither been refused a professional, occupational vocational license by any public or governmental licensing agency or regulatory authority, nor has such a license held by me ever been suspended or revoked, except as follows:

16. I have never been an officer, director, key employee or controlling stockholder of a company which, while I occupied any such position or capacity with respect to it, became
insolvent or was enjoined from or ordered to cease and desist from violating any law, except as follows:

17. Neither I nor any company of which I was an officer, director or key management person at the time has ever been subject to any civil action alleging fraud, negligence or violation of any applicable racketeering statutes (state or federal), except as follows:

18. I am not and none of the employees, officers or directors of: (name of company) _____ is an employee, officer or director of any other administrator, program manager, servicing organization or insurance producer of the Fund, nor do I or any of the employees, officers or directors of (name of company) _____ have a direct or indirect financial interest in any other administrator, program manager, servicing organization or insurance producer of the Fund, except as follows:
18a. Any direct or indirect financial interest or any position held as employee, officer or director in any other administrator, program manager, servicing organization, or insurance producer of the Fund, as described above, has been disclosed to the fund commissioners or executive committee, as applicable. (Yes/No)

Dated and signed this _____ day of _____ at ________________________________.

I hereby certify under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge and belief and further, by the affixation of my signature herein, I hereby give my certified consent to the New Jersey Department of Insurance to verify the representations and information supplied in response to all questions on the biographical data form, with any Federal, State, municipal or other agency which may have knowledge an/or information thereon.
State of _____

County of _____

________________________________personall

y appeared before me, personally known to me, who, being duly sworn, deposes and says that affiant executed the above instrument and that the statements and answers contained therein are true and correct to the best of affiant’s knowledge and belief.

Subscribed and sworn to before me this _____ day of _____.

________________________________________________

Notary Public

My Commission

Expires_______________

(SEAL)
DATA FORM SUMMARY

YEAR _____

Firm Name: ___________________________________________ 
__________________________________________

Address: 
__________________________________________
__________________________________________
__________________________________________

Phone: _________________________ Fax: 
_____________________________________

1.) List all parties having or deriving any interest, right or benefit in the firm.

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2.) List all senior officers and directors who will be servicing the Fund, along with a description of professional qualifications.

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<th>Name</th>
<th>Title</th>
<th>Qualifications</th>
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I hereby certify that the information on this disclosure is accurate and complete, and that I am an officer of the firm and am duly authorized to supply this information on behalf of the firm.

Signature:
Print: ______________________________

Title:
Date: ______________________________
STATEWIDE INSURANCE FUND

ACKNOWLEDGEMENT OF CORRECTIONS, ADDITIONS AND DELETIONS FORM

I, ____________________________________________

____________________________________________
of the firm

____________________________________________

hereby acknowledge that any corrections, additions and/or deletions

have been initialed and dated in this Submission Package.

____________________________________________

(Signature)
End of Submission Package
STATEWIDE INSURANCE COMPENSATION FUND

Sample SERVICE AGREEMENT
BETWEEN
Manage Care Company
AND THE
STATEWIDE INSURANCE FUND

THIS AGREEMENT entered into this 1st day of January, 2012 between the Statewide Insurance Fund (hereinafter referred to as the "Fund"), and ., a corporation of the , (hereinafter the "SERVICE PROVIDER"), having its principal place of business (hereinafter referred to as "SERVICE PROVIDER"), through a fair and open process, pursuant to N.J.S.A. 19:44A-20.4.

WHEREAS, the Statewide Insurance Fund, (hereinafter referred to as the "Fund"), has been organized under the provisions of N.J.S.A. 40A:10-36, et seq. and requires the regular services of a claims service company to provide managed care services; and

WHEREAS, ., is highly experienced in providing managed care services;

NOW, THEREFORE, IT IS AGREED by and between the FUND and the SERVICE PROVIDER as follows;

I. APPOINTMENT. The SERVICE PROVIDER is hereby appointed, through a fair and open process, pursuant to N.J.S.A. 19:44A-20.4, and retained as the Managed Care Organization for the FUND to provide managed care for workers compensation.
II. DEFINITIONS. The following definitions apply to this Agreement:

“Active Claim” means a reported claim for medical or indemnification payment where is required.

“Health Care Providers” means doctors, nurses, hospitals, physical therapists and all other licensed providers of health care and wellness services entitled to reimbursement under the worker’s compensation laws of New Jersey or any state.

“Network Health Care Providers” means health care providers with whom Service Provider has contracts through which Service Provider is able to provide to Fund lower health care costs.

"Reported Claim" means a notice of loss in written or verbal form for which payment or indemnification may be required, including potential claims wherein the FUND may not provide coverage but, nonetheless, has an obligation to provide a defense pursuant to a reservation of rights or similar instrument.

"Claim" means a demand for monetary compensation for any loss or damage by any person or medical, dental or other similar provider arising out of any single occurrence.

"Executive Committee" means the Executive Committee of the FUND.

"Managed Care" means the oversight of medical, dental and other similar claims to assure that the Fund pays the least medical, dental or other similar claims reasonably possible.

"Member" means public entities that are members of the Fund.
“Report Only Claims” means a claim for which there is not an immediate demand for compensation, but there may be such a claim in the future.

III. TERM. The term of this appointment shall commence on January 1, 2012, and continue to December 31, 2014, or until a successor is appointed in accordance with the terms and conditions of this Agreement and the FUND Bylaws. This agreement is subject to the availability and appropriation annually of sufficient funds. If sufficient funds are not available to meet the extended obligation of the agreement, the Fund reserves the right to cancel the extension of the agreement.

IV. TERMINATION OF AGREEMENT. Notwithstanding any other provision of this agreement, the FUND may terminate without cause this Agreement, at any time during the term thereof by the giving of ninety (90) days written notice to the SERVICE PROVIDER. The SERVICE PROVIDER may terminate in the event the FUND fails, without cause, to pay invoices, in the proper forms, due and owing, within sixty (60) days of a FUND meeting at which they have been presented for payment. The SERVICE PROVIDER shall give thirty (30) days written notice of its intent to terminate within which time period the FUND may pay any amounts in default and, if it does, the SERVICE PROVIDER shall not terminate.

V. AFFIRMATIVE ACTION. The affirmative action language, required by State law and attached as Exhibit A is incorporated in this Agreement. The term, “Contractor,” as referred to in such Exhibit A means the SERVICE PROVIDER. This Agreement will be null and void if the SERVICE PROVIDER fails to comply
with the Affirmative Action requirements imposed upon the SERVICE PROVIDER by the State of New Jersey.

VI. NEW JERSEY LAW. This Agreement shall be governed by, and construed in accordance with, the laws of the State of New Jersey.

VII. BINDING ON SUCCESSORS AND ASSIGNS. Except as otherwise provided herein, all terms, provisions and conditions of this Agreement shall be binding on and inure to the benefit of the parties hereto, their respective personal representatives, successors and assigns.

VIII. MODIFICATION. No modification of this Agreement shall be valid or binding unless the modification shall be in writing and executed by the FUND and the SERVICE PROVIDER.

IV. NO WAIVER. No waiver of any term, provision or condition contained in this Agreement, nor any breach of any such term, provision or condition shall constitute a waiver of any subsequent breach of any such term, provision or condition by either party, or justify or authorize the non-observance on any other occasion of the same or any other term, provision or condition of this Agreement by either party.

X. PARTIAL INVALIDITY. If any term, provision or condition contained in this Agreement, or the application thereof to any person or circumstances shall, at any time, or to any extent, be invalid or unenforceable, the remainder to this Agreement, or the application of such term or provision to persons or circumstances other than those as to which this Agreement is invalid or unenforceable, shall not be affected thereby, and each term, provision or condition
contained in this Agreement shall be valid and enforced to the extent permitted by "the law provided, however, that no such invalidity shall in any way reduce services to be performed by the SERVICE PROVIDER to the FUND.

XI. CAPTIONS. The captions or paragraph headings contained in this Agreement are solely for the purpose of convenience and shall not be deemed part of this Agreement for the purpose of construing the meaning thereof or for any other purpose.

XII. ASSIGNMENT. This Agreement shall not be assigned by the SERVICE PROVIDER without the specific written consent of the FUND. The FUND reserves the right to withhold its consent to assignment for any reason whatsoever.

XIII. INSURANCE. Except as elsewhere provided herein, SERVICE PROVIDER shall provide, at its own cost and expense, proof of the following insurance to the FUND:


Employers Liability: $1,000,000.00

B. General Liability: Minimum limit of liability:

Bodily Injury and Property Damage Each Occurrence: $2,000,000.00;

General Aggregate: $2,000,000.00;

Products and Completed Operations Aggregate: $2,000,000.00;

Personal and Advertising Injury: $2,000,000.00;

Fire Damage (any one fire): $50,000.00;
Medical Expense (any one person): $5,000.00.

C. Automobile Liability: Minimum limit of liability:
   Bodily Injury and Property Damage Combined Single Limit: $2,000,000.00;
   Uninsured and Underinsured Motorist Liability: $2,000,000.00;
   Hired an Non-owned Automobile Liability: $2,000,000.00.

D. Errors and Omissions: Minimum limit of liability of $1,000,000.00 for each claim and $1,000,000.00 annual aggregate.

E. Performance Bond: Full value of this Agreement.

   Proof of the above coverages shall be provided to the Administrator within thirty (30) days of the date of signing of the agreement, and in the event the SERVICE PROVIDER fails to supply required proof of insurance within the 30 days of receipt of a written notice of deficiency the FUND may terminate this agreement immediately upon retention of a replacement of claims administration services. The insurance companies for the above coverage must be licensed, solvent, and have an AM BEST rating of "A-" or better unless a lower rating is approved by the FUND. SERVICE PROVIDER shall not take any action to cancel or materially change any of the above insurance required under this Agreement without FUND approval. Maintenance of insurance under this section shall not relieve SERVICE PROVIDER of any liability greater than the insurance coverage.

   XIV. INDEMNIFICATION AND HOLD HARMLESS. SERVICE PROVIDER shall indemnify and hold the FUND, its Commissioners, and
appointed officials and local units harmless from any and all claims or liabilities arising out of the activities of the SERVICE PROVIDER, its employees, agents and subcontractors in connection with all activities undertaken by the SERVICE PROVIDER, pursuant to this Agreement. It is the intention of the parties that any claim for relief of any type being asserted against the FUND, its Commissioners, appointed officials and member local unit, based upon any act or omission of the SERVICE PROVIDER, its affiliates and successors, shall be the responsibility of the SERVICE PROVIDER, and the SERVICE PROVIDER shall hold the FUND, its commissioners, appointed officials and member local units harmless from same.

XV. INDEPENDENT CONTRACTOR STATUS. The SERVICE PROVIDER at all times shall be an independent contractor, and employees of SERVICE PROVIDER shall in no event be considered employees of the FUND. No agency relationship between the parties, except as expressly provided for herein, shall exist either as a result of the execution of this Agreement or performance thereunder.

XVI. ENTIRE AGREEMENT. This instrument contains the entire Agreement of the parties hereto and may not be amended, modified, released or discharged, in whole or in part, except by an instrument in writing signed by the parties hereto.

XVII. OWNERSHIP OF RECORDS.

A. Subject to applicable laws applicable to medical provider records, the FUND shall have the right to access and control of all files,
records and data of any kind electronic or written, of any kind relating to the FUND, regardless of whether the record was generated by the SERVICE PROVIDER or a subcontractor of the SERVICE PROVIDER.

B. The originals or copies of all files, records, data electronic or written relating to the operation and business of the FUND shall be turned over to the FUND, upon request by it. The FUND shall have the right to obtain from Service Provider the original and all copies of its records, upon request, regardless of the site stored. The SERVICE PROVIDER shall maintain and provide access to all files, records, data, electronic or written, of the FUND during the term hereof and for seven (7) years after the closing of the last claim the SERVICE PROVIDER handled for the FUND provided any costs or expenses of providing such access shall be borne by the FUND. Access shall be provided during normal business hours of SERVICE PROVIDER. The FUND shall provide five days advance notice of its request for access.

C. Information released to the SERVICE PROVIDER, or its subcontractors, by the FUND for the purpose of performing the services as outlined herein shall be used only in connection with the performance of said duties, and shall not be released to any third party without written permission of the Fund.
XVIII. NOTICE. All notices provided by either party shall be in writing and sent by regular or certified mail. Notices sent to the FUND shall be mailed to the FUND Administrator. Notice sent to the SERVICE PROVIDER shall be sent to:

XIX. CONFIDENTIALITY. Each party acknowledges that performance of the Agreement will involve access to and disclosure of data, rates, procedures, materials, lists, systems, and information (collectively "Information") belonging to the other party, employees or Fund members. All such information will be kept confidential and will not be disclosed to any third party, except to extent required by any law governing public entities.

In addition, each party will maintain the confidentiality of medical records and confidential patient information as required by law. The Fund shall keep the rates, charges to or amounts paid by or through any of its affiliates to health care providers strictly confidential and shall not disclose same to any third party under any circumstances whatsoever, except to the extent required by any law governing public entities.

XX. SERVICES-MANAGED CARE SERVICES. During the term of this Agreement the SERVICE PROVIDER shall provide Managed Care services to the Fund, including the following:

A. With respect to managed care the SERVICE CARE PROVIDER agrees to provide its full efforts and services to achieve, on behalf of the FUND, the following goals:
1. To provide appropriate, quality and timely care to FUND, its members and their employees.

2. To provide cost effective processing of claims of health care providers presented to the FUND for payment.

3. To encourage and see that FUND members’ employees are returned to work in an appropriate and expeditious manner.

4. To foster a caring attitude between employer and employee with the goal being to cure the employee of his/her work related injuries or illnesses as promptly and efficiently as possible so that the employee may return to gainful employment as soon as possible.

5. To provide timely and caring assistance to employees so as to reduce physical, emotional and psychological consequences of work-related disease or injury.

6. To decrease indemnity and medical expenses.

7. To decrease rehabilitation expenses.

8. To decrease litigation expenses.

B. SERVICE PROVIDER agrees the FUND will have access to the health care providers in the SERVICE PROVIDER’S network for health care providers deemed sufficient and acceptable by the Department of Health.

Attached hereto as Exhibit A is a list of the health care providers currently in the Service Providers PROVIDER is obligated to provide managed care to the FUND, its members.
and their employees it will arrange to have available to the FUND a network of health care providers comparable to that described in Exhibit A.

C. The SERVICE PROVIDER represents and agrees that the SERVICE PROVIDER has entered into contracts with the various health care providers listed on Exhibit A for the purpose of achieving reductions in the rates customarily charged by the health care provider. The FUND will be charged the most favorable rates available to a member of the SERVICE PROVIDER’S network. Upon demand of the FUND, or its designated representatives, the SERVICE PROVIDER will supply to the FUND, without charge, copies of the agreements between the SERVICE PROVIDER and the health care providers listed on Exhibit A which establish the rates to be charged to the FUND. The SERVICE PROVIDER agrees to periodically explain to the Administrator the savings being generated by the FUND. The SERVICE PROVIDER shall document its methods and procedures and shall explain the savings being achieved for the FUND.

D. The SERVICE PROVIDER shall maintain a highly trained, highly experienced team of Managed Care professionals that shall deliver superior professional service and technical expertise to FUND, its members and their employees.

E. The SERVICE PROVIDER agrees that all of its managed care accounts will be managed by a case manager supplied by SERVICE PROVIDER. The case managers shall be nurses (RNs) who will be supported by physician advisors. All persons providing Managed Care shall possess the
necessary education, training, experience and any licenses required by law to effectively and efficiently provide Managed Care services to the FUND. The SERVICE PROVIDER, through the case managers, will provide the following services:

1. Daily reporting and documenting of on the job injuries requiring health care treatment including the electronic filing to the required State Agencies.

2. Referrals of injured employees to Network Health Care Providers, if this can be done without compromise to the quality of health care provided to the employees of the FUND's members, as appropriate. Cased Managers will, to the best of their ability, refer employees to established Network Health Care Providers at the most advantageous rate available to the Fund.

3. Establishing an appropriate treatment plan with the health care provider or facility treating the injured employee.

4. Pre-certification of inpatient and outpatient health care procedures to assure that employees are receiving only appropriate and necessary treatment in consultation with the health care provider that are assigned to treat the employee.

5. Obtaining job description of the employees' functions when there is lost time or there is expected to be lost time from work.
6. Providing continuous contacts with the FUND’s Claim Administrator's claims adjusters, the employer and the injured employee to make sure that all involved persons are familiar with the progress of the claim.

7. Coordination of the injured employee's return to work so that the injured worker may return to work as promptly as is reasonably possible considering the nature of the injury and other factors related to the employee's employment.

8. Attend Safety Committee meetings, installation meetings or any other meetings at the request of the Fund.

F. The SERVICE PROVIDER agrees that all network medical care providers will agree to assist in providing appropriate care for employees and assistance in managing medical costs. The SERVICE PROVIDER shall contract with the health care providers so that each health care provider agrees that the primary physician shall be responsible to:

1. Evaluate the injured worker within twenty-four hours of injury and provide a report within forty-eight hours of injury.

2. Document at the initial visit and at each subsequent visit the time frames for treatment and the potential for return to work.

3. Assess the injured employee's job description and injury when there is lost time to evaluate when the employee may return to work. It shall be the primary care physician's responsibility, subject to medical necessity and work
conditions, to see that the injured worker returns to work as expeditiously as possible.

4. Complete such medical release forms as are appropriate.

5. Refer the injured worker to specialized care as necessary.

6. Maintain a complete and accurate history of broken and/or missed in and communicate same to Fund's claims administrator in a timely manner.

G. The SERVICE PROVIDER shall provide a complete and thorough review of all bills submitted by all health care providers. The SERVICE PROVIDER shall have in place review systems designed to recognize the accurate, reasonable and necessary charge for the services provided. If the health care provider is part of the SERVICE PROVIDER'S Network Health Care Providers then all discounts available to the FUND shall be applied. If not, then the SERVICE PROVIDER shall attempt to negotiate a discount or reduction in said bills to the greatest extent possible. Upon completion of the bill review an "explanation of benefits letter" will be sent to the health care provider which shall fully explain any reductions in charges and why full payment was not made. During the course of this process, the SERVICE PROVIDER shall identify any excessive, unnecessary or inappropriate charges and eliminate, reduce and/or negotiate down those charges. The SERVICE PROVIDER shall evaluate the treatment codes for all treatments provided for which a claim is made and shall compare those codes with the actual, documented treatment. The SERVICE PROVIDER shall identify and refuse to pay duplicate bills. Bills of a
more complicated nature shall be reviewed by registered nurses in the employment of the SERVICE PROVIDER. In the event that review of bills establishes that additional documentation is required, then the SERVICE PROVIDER shall demand said documentation from the health care provider.

H. The SERVICE PROVIDER, shall provide disability management of all injured employees. This shall include verification of an estimated return to work date after each visit to a health care provider, providing the health care provider with a copy of the Job worksheet which will describe the employee's job duties so that any lost time may be kept to a minimum and, when appropriate, the employee shall be returned to light duty or other employment as expeditiously as possible. The SERVICE PROVIDER shall obtain from the FUND’S members a job description for each injured employee so that this information can be submitted to the appropriate health care provider. In addition, the SERVICE PROVIDER shall coordinate the information from the health care provider and follow-up with the health care provider to assure that there is expeditious and appropriate return to work by the employee. In addition, the SERVICE PROVIDER shall monitor the appropriateness of care to ensure the minimum, necessary medical treatment is achieved in the shortest, most appropriate time frames.

I. The SERVICE PROVIDER shall maintain an 800 injury reporting hotline telephone number which shall be available 24 hours a day, 7 days a week for reporting claims, the processing of customer information and claims handling.
J. The SERVICE PROVIDER shall have its key local personnel conduct service calls as needed at each participating local unit for the purpose of establishing lines of communication and reporting procedures. Written reporting procedures will be posted at each Member's site.

K. The SERVICE PROVIDER communicate individually or through meetings with Members local units as to claims reporting procedures and requirements.

L. The SERVICE PROVIDER shall have the following automation capabilities available for assisting the FUND:
   1. State of the art electronic risk management system.
   2. Flexibility to access the system for standard and ad hoc reporting requirements.
   3. The ability to deliver customized, on demand, reports to pinpoint any problem areas with respect to managed care.
   4. The ability to capture customer requested specific data pertaining to managed care.
   5. The ability to compare pre and post program claims data.

M. Pursuant to N.J.A.C. 11:15-2.2b, unless the Executive Committee provides otherwise, the SERVICE PROVIDER shall be responsible to handle to completion of all managed care accounts.

N. The SERVICE PROVIDER agrees to provide all data and documents relating to managed care necessary to document the claims being handled, the amount claimed by each medical care provider by claim, the amount
paid to each medical care provider by claim, the amount of savings to the FUND by claim and in the aggregate and such additional information as shall be reasonably required by the FUND. In addition, the SERVICE PROVIDER shall:

1. Provide a reporting procedure for accidents occurring during and after normal business hours, during holidays, or on weekends, including a no charge to caller telephone number to report claims.

2. Provide the complete and competent handling of all reported claims.

3. Maintain a claim file for each reported claim and to preserve such records as required by this agreement, state statutes, regulations, the FUND's Bylaws and/or the requirements of the Executive Committee of the FUND. Such records shall be made available to the FUND upon request.

4. Submit monthly reports in a pre-agreed upon format as designated by the Executive Committee of the FUND, which reports shall be submitted as frequently as required by the Executive Committee. Submit year end report providing complete data by "FUND Year" in such a pre agreed format as designated by the Executive Committee and be in a form so as to be readily usable by all service professionals without further modification.
5. Collect and provide in such frequency as is reasonable and required by the Executive Committee such other information on claims or payment and other necessary information as may be requested by the FUND, its Executive Committee and Administrator.

O. The FUND shall have the right to perform such audits as it deems appropriate of the Managed Care activities of the SERVICE PROVIDER. At the request of the FUND, its auditor or any experts hired by the FUND to assist such audits, the SERVICE PROVIDER shall, at the FUND’s expense, provide or make available all documents necessary to conduct an audit, including but not limited to, bills, checks, copies of all audits performed by the SERVICE PROVIDER, copies or access to all electronic data pertaining to the FUND, contracts with providers, and all other documentation or data reasonably necessary to conduct a thorough audit.

P. The SERVICE PROVIDER shall comply with all laws applicable to Managed Care providers in New Jersey.

XXI. COMPENSATION.

For and in consideration of the services to be provided pursuant to this Agreement, the FUND will remit to the SERVICE PROVIDER a fee on a monthly basis to be determined as follows:

To be determined
SERVICE PROVIDER will be paid monthly through the submission of invoices to the claims administrator and payment made through the workers’ compensation loss fund. In the event that the services of the SERVICE PROVIDER are terminated by the FUND prior to the expiration of the term of this Agreement, the SERVICE PROVIDER will be paid for service rendered to the date of termination in accordance with the rates established in this agreement. For the 2013 & 2014 Fund years, the fee will be negotiated between the Fund and the SERVICE PROVIDER, as set forth in a letter agreement between the Fund and the Service Provider. However, any price change for the extension of the Agreement shall be based upon the price of the original contract as cumulatively adjusted pursuant to any previous adjustment or extension and shall not exceed the change in the index rate for the 12 months preceding the most quarterly calculation available at the time the agreement is renewed, unless mutually agreed to by the Executive Committee of the Fund and the SERVICE PROVIDER.

B. Intentionally Omitted.

C. Except in cases of medical emergency, the Service Provider will not be entitled to receive any savings income on any re-priced bills directed by Service Provider to an out of network health care provider without the prior written authority of the Fund.

D. If an audit is performed by the FUND of the managed care activities of the SERVICE PROVIDER, which reveals that SERVICE PROVIDER, has failed to take all discounts or reductions available to the FUND, or have unjustly
imposed charged on the FUND, then the SERVICE PROVIDER shall reimburse
the FUND for all charges incurred to perform the audit including auditing, legal or
any experts engaged by the FUND to assist in conducting the audit. Notice of the
audit must be provided 90 days in advance to the service provider.

XXII. SPECIAL PROVISIONS RELATING TO COMPENSATION. The
compensation set forth in Section XXI of this Agreement include:

A. All administrative staff, including support staff, necessary to perform
the duties required hereunder.

B. Use of all physical equipment, and there shall be no further charges
for rent, light, heat, office equipment or similar items unless required specifically
by the FUND.

C. In-house computer services and all software. All hardware loaned
or used in presentations at the request of the FUND. All hardware and/or
software is and shall remain the property of the SERVICE PROVIDER. All data
and record which pertain to the business and activities of the FUND shall,
however, be the property of the FUND and upon request of the FUND's
Executive Committee the SERVICE PROVIDER, at their cost, shall provide a
complete and current copy of all such data and records to the FUND's Executive
Committee in either hard copy or on computer tape or disk or both as the
FUND's Executive Committee may specify.

Furthermore, the SERVICE PROVIDER shall take all reasonable steps
necessary at no additional cost to the FUND to safeguard data files, reports or
other information from loss, destruction or erasure. Liability for cost or expense
of replacing for damages resulting from the loss of such data shall be borne by the SERVICE PROVIDER, unless at the time of loss said data was in the exclusive custody of the FUND.

D. The SERVICE PROVIDER and the FUND agree that the SERVICE PROVIDER may be receiving compensation from parties other than the FUND as a result of contracts for other services. The FUND agrees that all such compensation arrangements are not part of the compensation set forth in this agreement.

XXIII. BEST EFFORTS. The FUND shall use its best efforts to encourage FUND Members to promptly report in writing within 48 hours of reporting a claim verbally to the SERVICE PROVIDER all information required by SERVICE PROVIDER to efficiently and competently handle the claim.

XXIV. SERVICE PROVIDER REPRESENTATIVE. The SERVICE PROVIDER’s designated representative is Thomas Mooney.

XXV. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: To the extent required by law, SERVICE PROVIDER agrees to adhere to all Health Insurance Portability and Accountability Act (“HIPAA”) rules and regulations, as amended by 45 C.F.R. § 164.501, et. seq.

(a) The SERVICE PROVIDER shall:

(i) Implement any HIPAA required policies, training and supervision.
(ii) Provide the Fund copy of its HIPAA policies and
documentation of any HIPAA-related training
conducted by SERVICE PROVIDER.

(b) Indemnification

(i) Any HIPAA violations committed by Administrator or
its employees and agents shall be the sole
responsibility of SERVICE PROVIDER and the Fund
is not responsible for any HIPAA violations that result
in whole or in part from SERVICE PROVIDER’s work.

(ii) SERVICE PROVIDER shall hold the Fund harmless
from any and all liabilities related to HIPAA violations,
including but not limited to, fines, penalties, and
attorneys’ fees and costs that result in whole or in part
from SERVICE PROVIDER’s work.

(c) Reporting requirement

(i) SERVICE PROVIDER shall, by April 1, 2007, provide
the Fund with a certification as to whether the
SERVICE PROVIDER is required by law to comply
with the rules and regulations of HIPAA.

(ii) If the SERVICE PROVIDER is required by law to
comply with the rules and regulations of HIPAA, by
April 1, 2007, it will provide the Fund with a plan of
action as to how it intends to comply with the rules
and regulations of HIPAA.

The SERVICE PROVIDER agrees to notify the FUND in writing of any request to change its designated representative.

XXVI. Business Registration Certificate: The SERVICE PROVIDER has received a Business Registration Certificate from the State of New Jersey as evidenced by the attached copy of the Certificate. This Agreement will be null and void if the SERVICE PROVIDER fails to supply and maintain a current Business Registration Certificate.

IN WITNESS WHEREOF, this Agreement has been executed on this day of ____________, 2011 for the purposes and the term specified herein.

STATEWIDE INSURANCE FUND

ATTEST:

____________________________  By:____________________________
Chairperson

ATTEST:

____________________________  By:____________________________
President
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**Related Codes: 0250 PHARMACY, 0450 EMERG ROOM**

**Applicant:** DEITZ & HAMMER

**Patient Information:**
- **Address:** PO BOX 68
- **City:** NEWTON NJ 07860
- **Name:** ENRIQUEZ
- **Position:** MELISSA

**Additional Information:**
- **Certifications:** ARE MADE A PART HEREOF.
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SEP 20 2011
BY D&H
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**PAGE 1 OF 1**

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**TOTALS:** 2435.00

**WORKERS COMPENSATION:** O

**INSURER'S NAME:** YOO, SAM

**INSURER'S UNIQUE ID:** SWM036355

**RECEIVED:** SEP 20 2011

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**PAGE 1 OF 1**

**CREATION DATE 06/02/11**

**TOTALS 7481.00**

**WORKERS COMPENSATION**

**7481.00**

**VERBAL AUTH**

**7949 V4365**

**VERBAL AUTH**

**99641**

**LAST TOZZI JOHN**

**LAST**

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**Total Charges:** 105338.776

**RBRV:** CSG
**COB:** CSG

**WOEHL,MICHELLE**
18 SWM032194
TWP OF JEFFERS

**TOWNHSH OF JEFFERS**

**Remarks:** CSG
B3282N000000X

**Certification:**
The certification on the reverse applies to this bill and is made a part hereof.
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**Claim Number:** 202158771

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- Occurrence Category: 1
- Occurrence Category Description: 42600

**Code: 0450, Description: EMERGENCY ROOM**
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- Occurrence Span To: 082811
- Occurrence Category: 1
- Occurrence Category Description: 63500

Total Charges: 106200
STATEWIDE INSURANCE
PO BOX 68
NEWTON NJ 07860

0259 DRUGS/OTHER
0329 DX X-RAY/OTHER
0450 EMERGENCY ROOM

RECEIVED
SEP 19 2011
BY D&H

STATEWIDE INSURANCE

CREATION DATE 091211 TOTALS 396725

1134125016
396725 310057 13002

S101404E2080010

91940

114189859 1GC12345

1203282N00000X

NUBC National Uniform Billing Committee

100-06 CMR-1000
HEALTH INSURANCE CLAIM FORM

30. SIGNATURE OF PHYSICIAN OR SUPPLIER (Optional)

Thomas F Seck, MD
09/14/2011

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)
HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPSA GROUP
   (Medicare #) (Medicaid #) (Spouse's SSN) HEALTH PLAN (PPO OR C2)

2. FEEA
   (A/P #) (Other)
   (Blk Lung, SSA #)

3. PATIENT'S BIRTH DATE
   MM DD YY

4. SEX
   M F

5. PATIENT RELATIONSHIP TO INSURED
   Spouse Child Other

6. PATIENT'S STATUS
   Single Married X Other

7. ZIP CODE
   07081

8. 11. INSURED'S POLICY GROUP OR FEEA NUMBER
   P.O. BOX 68
   NEWTON, NJ 07860

9. OTHER INSURED'S NAME: (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. a. INSURED'S DATE OF BIRTH
    MM DD YY
    M F

   b. EMPLOYER'S NAME OR SCHOOL NAME

   c. INSURANCE PLAN NAME OR PROGRAM NAME

   d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

   e. COVERED OR NOT COVERED

12. a. OTHER INSURED'S POLICY OR GROUP NUMBER

   b. OTHER INSURED'S DATE OF BIRTH
    MM DD YY
    M F

   c. EMPLOYER'S NAME OR SCHOOL NAME

   d. INSURANCE PLAN NAME OR PROGRAM NAME

   e. RESERVED FOR LOCAL USE

READ BACK OF FORM BEFORE COMPLETING AND SIGNING THIS FORM.

SIGNATURE ON FILE

DATE: 08/30/11

14. DATE OF CURRENT ILLNESS (First symptom or Injury (Accident) or Pregnant/LMP)

15. IF PATIENT HAS HAD SAME NAME OR SIMILAR ILLNESS GIVE FIRST DATE

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SICKNESS

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24 BY LINE)

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE

25. FEDERAL TAX ID NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?
   (For gnd. claims, see back)

28. TOTAL CHARGE AMOUNT PAID BALANCE DUE
   $ $ $

29. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
   (I certify that the statements on this reverse apply to this bill and are made a part thereof)

30. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. SIGNATURE OF PHYSICIAN, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE

33. SIGNATURE OF PHYSICIAN, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE

PLEASE PRINT OR TYPE
**Dietz & Hamer**
**Box 68**
**Newton, NJ 07860-0068**

**HEALTH INSURANCE CLAIM FORM**

1. **MEDICAID**
   - (Medicaid #: [Redacted])

2. **GROUP PLAN NAME**
   - PCNA (Member ID: [Redacted])

3. **PATIENT'S NAME**
   - (Last Name, First Name, Middle Initial)

4. **INSURED'S NAME**
   - (Last Name, First Name, Middle Initial)

5. **ADDRESS**
   - 599 Fayette St
   - Perth Amboy, NJ

6. **INSURANCE PLAN NAME**
   - PER035909

7. **DATE OF BIRTH**
   - MM: [Redacted] DD: [Redacted] YY: [Redacted]

8. **SEX**
   - M

9. **EMPLOYMENT**
   - (Current or Previous)
   - X: YES
   - N: NO

10. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**
    - (Relate Items 1, 2, 3 or 4 to Item 54E by Line)
    - 692.6

11. **DATE(S) OF SERVICE**
    - MM: [Redacted] DD: [Redacted] YY: [Redacted]

12. **PROCEDURE(S)**
    - [Redacted]

13. **DIAGNOSIS**
    - [Redacted]

14. **TOTAL CHARGES**
    - $128.79

15. **AMOUNT PAID**
    - $0.00

16. **BALANCE DUE**
    - $128.79

---

**SIGNATURE ON FILE**

**SIGNATURE ON FILE**

**DATE**

**FILE**

**RECEIVED**

**SEP 20 2011**

**B Y D & H**

---

**ADDRESS**

**CMC - NJN Edison**

**Concentra Medical Centers**

**135 Haritan Center Pkwy**

**EDISON, NJ 08837**

**SIGNED**

**09/03/2011**

---

**FEDERAL TIN NUMBER**

**22-3473542**

---

**PHYSICIAN OR SUPPLIER INFORMATION**

**NAME**

**Thomas F Seck, MD**

---

**NNUC Instruction Manual available at:** www.nucc.org

**APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)**
HEALTH INSURANCE CLAIM FORM

WORKER'S COMPENSATION 61

1. MEDICARE [Medicare #] [Medicaid #]
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   3. PATIENT'S BIRTH DATE
      4. INSURED'S NAME (Last Name, First Name, Middle Initial)
      5. PATIENT RELATIONSHIP TO INSURED
         Mother, Father, Spouse, Child, Sibling, Other
      6. INSURED'S ADDRESS (No., Street)
      7. CITY OF PASSAIC
      8. ZIP CODE
         CITY
         STATE
         N.J
      9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
      10. IS PATIENT'S CONDITION RELATED TO:
          a. OTHER INSURED'S POLICY OR GROUP NUMBER
             a. EMPLOYMENT? (Current or Previous)
                YES NO
             b. AUTO ACCIDENT?
                YES NO
             c. EMPLOYER'S NAME OR SCHOOL NAME
             d. OTHER CONDITION?
                YES NO
      11. INSURED'S POLICY GROUP OR FECA NUMBER
          a. EMPLOYER'S DATE OF BIRTH
             m M F
          b. AUTO ACCIDENT? PLACE (State)
             YES NO
          c. EMPLOYER'S NAME OR SCHOOL NAME
          d. OTHER CONDITION?
             YES NO
      12. SIGNATURE OF INSURED OR AUTHORIZED PERSON'S SIGNATURE
          I authorize the release of any medical or other information necessary
          to process this claim. I also request payment of government benefits
          either to myself or to the party who accepts assignment below.
      13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
          I authorize payment of medical benefits to the undersigned
          physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS
    08 28 11
    15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
    GIVE FIRST DATE
    16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
        FROM
        TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
18. HOSPITALIZATION DATES RELATED TO CURRENT ILLNESS
    FROM
    TO

19. RESERVED FOR LOCAL USE

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
    (Relate Items 1, 2, 3 or 4 to Item 24 by Line)
    1. 846.0
    2. 847.0
    3. 923.0
    4. F928.9

21. FEPA JOBS OR SECTIONS
    A. FROM
       B. PROCEDURE, SERVICES, OR SUPPLIES
       C. DESCRIPTION
       D. MODIFIER
       E. MODIFIER

22. TOTAL CHARGE

23. BILLING PROVIDER INFO & PH
    888-293-7165

24. SIGNATURE OF PHYSICIAN OR SUPPLIER
    WOLOZEN, JOHN

25. FEDERAL TAX I.D. NUMBER

26. SERVICE FACILITY LOCATION INFORMATION

27. ACCEPT ASSIGNMENT?
    YES NO

28. AMOUNT PAID

29. BALANCE DUE

30. COMPLETE INFORMATION AVAILABLE AT: www.nucc.org
HEALTH INSURANCE CLAIM FORM

1. MEDICARE  Medicaid  TRICARE  CHAMPUS  CHAMPVA  GROUP HEALTH PLAN  FECA  OTHER
   (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID) (SSN or ID) (SSN) (ID)

2. PATIENT'S BIRTH DATE  SEX
   12-20-1973  M  F

3. PATIENT'S RELATIONSHIP TO INSURED
   Self  Spouse  Child  Other

4. PATIENT'S STATUS
   Single  Married  Other

5. IS PATIENT'S CONDITION RELATED TO:
   a. EMPLOYMENT? (Current or Previous)  YES  NO
   b. AUTO ACCIDENT?  YES  NO
   c. OTHER ACCIDENT?  YES  NO

6. INSURED'S DATE OF BIRTH  đạo  ชาย ผู้หญิง
   MM  DD  YY

7. INSURED'S SEX
   M  F

8. INSURED'S NAME OR SCHOOL NAME
   a. OTHER INSURED'S Policy or Group Number
   b. OTHER INSURED'S Date of Birth  MM  DD  YY  SEX
   c. EMPLOYER'S NAME OR SCHOOL NAME
   d. INSURANCE PLAN NAME OR PROGRAM NAME

9. NO OTHER COVERAGE

10. RESERVED FOR LOCAL USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S Name OR AUTHORIZED PERSON'S SIGNATURE: authorize payment of medical benefits to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)
   MM  DD  YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE  MM  DD  YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM  MM  DD  YY  TO  MM  DD  YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE  JOHN HURLEY

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM  MM  DD  YY  TO  MM  DD  YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB?  YES  NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)
   RECEIVED 715 16

22. MEDICAID RESUBMISSION CODE

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE
   From  MM  DD  YY  To  MM  DD  YY
   B. PLACE OR SERVICE
   C. EMG
   D. PROCEDURES, SERVICES, OR SUPPLIES
   E. MODIFIER
   F. POINT OF DIAGNOSIS

25. FEDERAL TID NUMBER  SSN EIN

26. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

27. ACCEPT ASSIGNMENT?  YES  NO

28. TOTAL CHARGE  $ 240.00

29. AMOUNT PAID  $ 0.00

30. BALANCE DUE  $ 240.00

31. SERVICE FACILITY LOCATION INFORMATION

32. BILLING PROVIDER INFO & PH 732 855 9751

33. BILLING PROVIDER INFO & PH 732 855 9751

MICHAEL HOLMGREN MT

SIGNED 06-17-2011

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APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

901616
### HEALTH INSURANCE CLAIM FORM

**APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05**

#### On File Information

- **Name:** [Redacted]
- **Social Security Number (SSN):** 800329236
- **Date of Birth:** 02/14/73
- **Sex:** F

#### Insured's Information

- **Insured's ID Number:** CPW11192017
- **Date of Birth:** 02/14/73
- **Sex:** F

#### Patient Information

- **Name:** [Redacted]
- **City:** Clifton, NJ
- **State:** NJ

#### Other Insured's Information

- **Name:** [Redacted]
- **City:** [Redacted]
- **State:** [Redacted]

#### Employee Information

- **Name:** [Redacted]
- **City:** [Redacted]
- **State:** [Redacted]

#### Date of Current Illness

- **Date:** 09/12/2011

#### Diagnosis

- **ICD-10 Code:** J83.21

#### Billing Information

- **Provider:** [Redacted]
- **Tax ID Number:** [Redacted]
- **Address:** Clifton, NJ 07013

#### Claim Signature

- **Date:** 9/12/2011

---

**NUCC Instruction Manual available at:** www.nucc.org

**APPROVED OMB-0038-0090 FORM CMS-1500 (08-04)**
**HEALTH INSURANCE CLAIM FORM**

**1. MEDICARE**

- [ ] MEDICAID
- [ ] TRICARE
- [ ] CHAMPVA
- [ ] GROUP HEALTH PLAN
- [ ] FECA/BUSLING/BENEFIT PLAN

**2. PATIENT'S NAME**

- [ ] MEDicaid #
- [ ] (SSN or ID)
- [ ] Company Name
- [ ] Member ID

**3. PATIENT'S BIRTH DATE**

- [ ] MM
- [ ] DD
- [ ] YY

**4. INSURED'S NAME**

- [ ] Last Name
- [ ] First Name
- [ ] Middle Initial

**5. PATIENT'S RELATIONSHIP TO INSURED**

- [ ] Self
- [ ] Spouse
- [ ] Child
- [ ] Other

**6. INSURED'S ADDRESS**

- [ ] City
- [ ] State
- [ ] Zip Code

**7. INSURED'S POLICY GROUP OR PECIA NUMBER**

**8. INSURED'S DATE OF BIRTH**

- [ ] MM
- [ ] DD
- [ ] YY

**9. OTHER INSURED'S NAME**

- [ ] Last Name
- [ ] First Name
- [ ] Middle Initial

**10. OTHER INSURED'S POLICY OR GROUP NUMBER**

**11. OTHER INSURED'S DATE OF BIRTH**

- [ ] MM
- [ ] DD
- [ ] YY

**12. OTHER INSURED'S DATE OF BIRTH**

- [ ] MM
- [ ] DD
- [ ] YY

**13. OTHER INSURED'S DATE OF BIRTH**

- [ ] MM
- [ ] DD
- [ ] YY

**14. OTHER INSURED'S DATE OF BIRTH**

- [ ] MM
- [ ] DD
- [ ] YY

**15. EMPLOYMENT?**

- [ ] Current or Previous

**16. EMPLOYER'S NAME**

- [ ] School Name
- [ ] Employer's Name

**17. INSURANCE PLAN NAME OR PROGRAM NAME**

**18. IS THERE ANOTHER INSURED'S NAME?**

- [ ] Yes
- [ ] No

**19. IS THERE ANOTHER INSURED'S NAME?**

- [ ] Yes
- [ ] No

**20. OUTSIDE LAB?**

- [ ] Yes
- [ ] No

**21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

**22. MEDICARE RESUBMISSION CODE**

**23. PRIOR AUTHORIZATION NUMBER**

**24. A. DATE(S) OF SERVICE**

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<th>MM</th>
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<th>MM</th>
<th>DD</th>
<th>YY</th>
<th>Type</th>
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<th>Chrgs</th>
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<td>NPI</td>
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</table>

**25. FEDERAL ID NUMBER**

- [ ] SSN
- [ ] EIN

**26. PATIENT'S ACCOUNT NO.**

**27. ACCEPT ASSIGNMENT?**

- [ ] Yes
- [ ] No

**28. TOTAL CHARGE**

- [ ] $186.00

**29. AMOUNT PAID**

- [ ] $0.00

**30. BALANCE DUE**

- [ ] $186.00

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER**

**32. SERVICE FACILITY LOCATION INFORMATION**

**33. BILLING PROVIDER INFO & PH #**

- [ ] Multicare Inc.
- [ ] 201-460-1001
- [ ] 253 Van Buren St.
- [ ] Lyndhurst, NJ 07071

**NUCC Instruction Manual available at:** www.nucc.org

**PLEASE PRINT OR TYPE**

**APPROVED OMB-0938-0993 FORM CMS-1500 (08-05)**
# HEALTH INSURANCE CLAIM FORM

**First MCO**  
PO BOX 5010  
ATTN: BILLING/CPU DEPT  
PARSIPPANY, NJ 07054

<table>
<thead>
<tr>
<th>1. MEDICARE</th>
<th>MEDICAID</th>
<th>TRICARE</th>
<th>CHAMPUS</th>
<th>CHAMPVA</th>
<th>GROUP HEALTH PLAN (SSN or ID)</th>
<th>FECA BLK LUNG (SSN)</th>
<th>OTHER (ID)</th>
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<th>3. PATIENT'S BIRTH DATE</th>
<th>SEX</th>
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<td>04/13/1963</td>
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<th>6. PATIENT RELATIONSHIP TO INSURED</th>
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<tr>
<td>Spouse</td>
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<th>8. PATIENT STATUS</th>
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<tr>
<td>Single</td>
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<th>10. IS PATIENT'S CONDITION RELATED TO:</th>
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<td>b. OTHER INSURED'S DATE OF BIRTH</td>
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<td>SEX</td>
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<thead>
<tr>
<th>12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE</th>
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<tr>
<td>Signature on file</td>
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<th>14. DATE OF CURRENT ILLNESS OR INJURY:</th>
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<td>05/21/07</td>
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<tr>
<th>21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:</th>
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<td>780.6</td>
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<th>24. DATE(S) OF SERVICE</th>
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<th>25. FEDERAL TAX ID NUMBER</th>
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<td>94-2486898</td>
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<th>26. PATIENT'S ACCOUNT NO.</th>
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<th>27. ACCEPT ASSIGNMENT?</th>
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<td>YES</td>
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<th>29. TOTAL CHARGE</th>
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<td>$460.00</td>
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<th>32. SERVICE FACILITY LOCATION INFORMATION</th>
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<tr>
<td>MONMOUTH MEDICAL CENTER</td>
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<th>33. BILLING PROVIDER INFO &amp; PH. #</th>
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<tr>
<td>EMERGENCY MEDICAL ASSOCIATES</td>
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</table>

**NUCC Instruction Manual available at: www.nucc.org**

**APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)**
HEALTH INSURANCE CLAIM FORM

1. MEDICARE   MEDICAID  CHAMPUS  CHAMPSA  GROUP HEALTH PLAN (INSN or ID)  PEECA BLK LUNG (INSN)  OTHER
   (Medicare #) (Medicaid #) (Sponsor’s IIN) (Y-A Fie #) X   (ID)  X

2. PATIENT’S BIRTH DATE
   M   DD   YY  4   13   1968  X

3. PATIENT’S CONDITION RELATED TO ILLNESS
   YES  NO
   a. EMPLOYMENT? (CURRENT OR PREVIOUS)
   b. AUTO ACCIDENT? PLACE (STATE)

4. PATIENT’S PREVIOUS ADDRESS
   CITY, OF L
   STATE
   ZIP CODE
   TELEPHONE (INCLUDE AREA CODE)
   (908) 222-7000

5. PATIENT’S CONDITION RELATED TO INJURY
   YES  NO
   a. DEFENDANT
   b. PERSON CURRENTLY RESPONSIBLE

6. INSURED’S NAME (Last Name, First Name, Middle Initial)
   CITY
   STATE

7. INSURED’S ADDRESS (NS., Street)
   ZIP CODE
   TELEPHONE (INCLUDE AREA CODE)
   (908) 222-7000

8. PATIENT’S RELATIONSHIP TO INSURED
   a. SPOUSE
   b. CHILD
   c. OTHER

9. PATIENT’S ADDRESS
   CITY
   STATE
   ZIP CODE

10. PATIENT’S CONDITION RELATED TO INJURY
   YES  NO
   a. EMPLOYMENT? (CURRENT OR PREVIOUS)
   b. AUTO ACCIDENT?

11. PATIENT’S ADDRESS
   CITY
   STATE
   ZIP CODE
   TELEPHONE (INCLUDE AREA CODE)
   (908) 222-7000

12. PATIENT’S CONDITION RELATED TO INJURY
   YES  NO
   a. EMPLOYMENT? (CURRENT OR PREVIOUS)
   b. AUTO ACCIDENT?

13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE I authorize payment of medical beneﬁts to the undersigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS
   M   DD   YY
   YES
   9   30   2005

15. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
   CITY
   STATE

16. DATE OF BIRTH
   M   DD   YY
   YES
   8   9   2005

17. DATE OF CURRENT ILLNESS
   M   DD   YY
   YES
   8   9   2005

18. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
   (RELATE ITEMS 1,2,3, OR 4 TO ITEM 24E BY LINE)
   1. 724.2
   2. 719.46

20. OUTSIDE LAB?
   YES
   NO

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
   X
   3.

22. MEDICARE RESUBMISSION CODE
   ORIGINAL REP. NO.

23. PRIOR AUTHORIZATION NUMBER

24. DATE(S) OF SERVICE
   FROM MM   DD   YY
   TO MM   DD   YY
   PROCEDURES, SERVICES, OR SUPPLIES
   (EXPLAIN UNUSUAL CIRCUMSTANCES)
   DIAGNOSIS CODE
   $11111
   25. FEDERAL TAX I.D. NUMBER
   63113454-513

26. PATIENT’S ACCOUNT NO.

27. ACCEPT ASSIGNMENT?
   YES
   NO
   FOR Gov. Plan, see basic

28. TOTAL CHARGE
   $239.00

29. AMOUNT PAID
   $0.00

30. BALANCE DUE
   $0.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
   SIGNATURE ON FILE
   (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
   ONEILL, PT, JEFFREY
   QA01154600 08-16-2005

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE)
   HEALTHSOUTH TINTON FALLS
   775 SHREWSBURY AVE
   TINTON FALLS  NJ  07724

33. PHONE
   800 226 0024

34. PHYSICIAN’S BILLING NAME, ADDRESS, ZF CODE
   DEPT AT 40036
   HEALHTSOUTH HOLDINGS INC
   ATLANTA  GA  31192-0036

35. PLEASE PRINT OR TYPE

(APPROVED BYAMA COUNCIL ON MEDICAL SERVICE 898)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)  FORM RBB-1800,
FORM OWCP-1500
HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA
   (Medicare #) (Medicaid #) (Sponsor’s SSN) (VA File #)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE
   MM DD YYYY

4. SEX
   M F

5. PATIENT RELATIONSHIP TO INSURED
   Self Spouse Child Other

6. PATIENT'S STATUS
   Single Married Other

7. EMPLOYER'S NAME OR SCHOOL NAME

8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

9. OTHER INSURED'S POLICY OR GROUP NUMBER

10. IS PATIENT'S CONDITION RELATED TO:
     A. EMPLOYMENT? (CURRENT OR PREVIOUS)
        YES NO
     B. AUTO ACCIDENT? PLACE (State)
        YES NO
     C. OTHER ACCIDNET? YES NO

11. INSURED'S POLICY GROUP OR PECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize the release of any medical or other information necessary
    to process this claim. I also request payment of benefits directly
    to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
    I authorize payment of medical benefits to the undersigned physician or supplier
    for services described below.

14. DATE OF CURRENT ILLNESS:
    MM DD YYYY

15. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

16. RESERVED FOR LOCAL USE

17. I.D. NUMBER OF.RefERRING PHYSICIAN

18. RESERVED FOR LOCAL USE

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
   (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24 BY LINE)

20. MEDICAID RESUBMISSION CODE

21. PRIOR AUTHORIZATION NUMBER

22. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
    FROM TO

23. OUTSIDE LAB TEST Charges
    YES NO

24. DATE(S) OF SERVICE
    FROM TO

25. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

26. PHYSICIAN OR SUPPLIER INFORMATION
   SIGNATURE

27. ACCEPT ASSIGNMENT?
   X YES NO

28. TOTAL CHARGE
   $239.00

29. AMOUNT PAID
   $0.00

30. BALANCE DUE
   $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER

32. PHONE #
   800 288 0024

33. PHYSICIAN'S BILLING NAME, ADDRESS, ZIP CODE

34. DEPT AT

35. AMOUNT PAID
   $0.00

36. SIGNATURE

37. DATE

(Approved by AMA Council on Medical Service 8/88)

PLEASE PRINT OR TYPE