Capital BLUE

PROVIDER CAPITATION RATE DETERMINATION
Information Sheet

Provider Group Name: ______________________ ***Date:*** ______________

Main Address: ______________________ ***County:*** ______________

Provider Type: ☐ Family Practice/Internal Medicine ☐ Pediatrics

PCP/Office Manager Signature: ______________________

Rates:

- ☐ Commercial HMO Rates
- ☐ Medicare Advantage HMO Rates

Lab Arrangement:

- ☐ PCP Capitated
- ☐ Third Party Lab
- ☐ Quest Lab
- ☐ Health Network Lab

Medicare Advantage HMO Rates Only:

- ☐ Performs Inpatient Hospital Services
- ☐ Does not perform Inpatient Hospital Services

Adjusted Rate Information (Please check if PCP **will be performing** the following services):

- ☐ Emergency Department Services (B)
- ☐ Inpatient Hospitalizations (C)
- ☐ Suturing of Lacerations (D)
- ☐ Control of Nasal Hemorrhage (E)
- ☐ Suture Removal (F)
- ☐ Incision and Drainage of Abscesses (G)
- ☐ Excision of Warts, Cysts, and Benign Lesions (H)
- ☐ Treatment of Localized Burns (I)
- ☐ Removal of Foreign Bodies (J)
- ☐ Treatment of Sprain and Dislocations (K)
- ☐ Avulsion of Nails (M)
- ☐ Arthrocenteses (N)
- ☐ EKGs (O)
- ☐ Proctosigmoidoscopies (P)
- ☐ Audiometry (Q)
- ☐ Spirometry (R)
- ☐ Allergy Testing (Y)
- ☐ Physical Medicine (L)
- ☐ Phlebotomy
- ☐ Hbg/Hct and Urinalysis
- ☐ Quick Strep

FOR INTERNAL USE ONLY

- ☐ New Provider Group
- ☐ Existing Provider ⟹ ☐ Contract Exhibit Needed ______________
- ☐ Harrisburg Tier
- ☐ Lehigh Valley Tier
- ☐ Northern Tier

Comments:

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