LOUISIANA REGIONAL PHO
PHYSICIAN HOSPITAL ORGANIZATION

HEALTHCARE BENEFITS QUESTIONNAIRE for 2017 – 2018

Company Name: _____

Mailing Address: _____ Parish: _____

Benefits Liaison: _____ Email: _____

Office Telephone: _____ Office Fax: _____

Is your Company Self-Insured? **YES** **NO**

Does your Company use a Health Insurance Broker*? **YES** **NO**

*Broker Name: _____ Phone Number: _____

Does your Company have a Medical Home? _____

What is the estimated number of Employees & Dependents that your company has insured? _____

Please list the Residential Zip Codes represented by your Covered Employees & Dependents? _____,

_____, _____, _____, _____, _____, _____, _____.

What Health Insurance Plan/Options does your Company currently offer to Employees?

1. Name: _____
2. Name: _____

What Health Insurance Plan/Options will your Company offer to Employees in 2018?

1. Name: _____
2. Name: _____

If your Benefit Plan is a PPO or POS, are there out-of-network benefits? **YES** **NO**

Do you offer Urgent Care Clinic benefits? **YES** **NO**

Company Policy Renewal Month: _____

Please RETURN this form at your earliest convenience by EMAIL to julie.simpson@hcahealthcare.com OR by FAX to 318-769-7589*

Thank you for taking the time to complete this valuable survey!