# California Medical Data Call

Insurer Group Profile and Contact Designation

**Form 101 (Rev. 09/2022)**

# Instructions

### Purpose of Form

**This form is for use by WCIRB member insurers (Insurers)** to designate the insurance companies within an existing NAIC group that will be reporting together (Insurer Group) and the Medical Data Submitter(s) that will report MDC information on behalf of those Insurers. A Medical Data Submitter (Submitter) is any entity that is authorized by the Insurer Group to report MDC data to the WCIRB, including an Insurer or Third Party Entity (TPE). This form must be completed for each unique Insurer Group created. The designated Insurer Group and reporting Submitter Contacts will receive reports and related MDC communications via email. Timeliness, completeness, and accuracy of submissions, as detailed within the California Medical Data Transaction Data Quality Assurance Program, are based at the Insurer Group level.

### Section A — Insurer Group Information

- To establish a new Insurer Group, which must be an NAIC group or a subset of an NAIC Group, create a unique Insurer Group Name for MDC reporting. Each new Insurer Group must have an associated NCCI Carrier Code which must be one of the NCCI Carrier Codes assigned to one of the Insurers within the Insurer Group and it must be the same NCCI Carrier Code that will be used in the Submission Control Record's Carrier Group Code field in the files submitted to WCIRB.
- List all the Insurer Group Members and each Insurer's NCCI Carrier Code.
- For new Insurer Groups, indicate the number of Submitters that will be reporting on behalf of the Insurer Group. Include both TPE Submitters and Insurer Submitters in the count. The number of Submitters should correspond to the number of Submitters identified in Section C.

### Section B — Insurer Group Contact Information

Provide the Insurer Group MDC Legal, Primary, Secondary, and Signatory Contacts. All Insurer Group contacts must be affiliated with one of the Insurers whose data is being reported, and may not be employees of the TPE. The Insurer Group Primary Contact will automatically receive MDC reports and communications via email, and the Secondary Contact may elect to receive MDC reports and communications by marking the box in this section to indicate their election.

### Section C — Submitter Contact Information/Insurer List

In Part 1, indicate whether the Submitter for the list of Insurers identified in Part 2 is a TPE or an Insurer and provide the Submitter's company information. For each Submitter/Insurer List combination, attach an additional, completed Section C to your submission. Additionally, if the Submitter is either a TPE or an Insurer that is not included in the Insurer Group, you must also complete WCIRB Form 902.

Provide the requested information for the Submitter Contacts. The Submitter MDC Primary Contact will automatically receive MDC reports and communications via email, but the Secondary Contact may elect to receive MDC reports and communications by marking the box in this section to indicate their election.

In Part 2, list each of the Insurer Names, NCCI Carrier Codes and, if applicable, Policy Dates for which MDC data will be reported by the Submitter(s) listed in Section C, Part 1. If you do not want to restrict the time period for which a Submitter is providing MDC data, then do not enter any dates in the Policy Date. If you want to restrict either the beginning or end of the time period for which the Submitter will provide MDC data then enter the applicable Policy Effective Date range.

### Use of Third Parties

To authorize a TPE to submit medical transaction data on its behalf, the Insurer must complete WCIRB Form 902, Third Party Entity Registration (Form 902) and then sign a Consent to Use Third Party Entity and Agreement to Indemnify (TPE Agreement). Form 902 can be accessed on the WCIRB's website **wcirb.com**.

### Form Submission

This form can be completed electronically, printed or typed and emailed or mailed to the following:

Email transactiondata@wcirb.com
Mail WCIRB Medical Data Call
1901 Harrison St., 17th Floor
Oakland, CA 94612

### Questions/Additional Information

If you have questions about this form, email the WCIRB at transactiondata@wcirb.com.

# California Medical Data Call

## Insurer Group Profile and Contact Designation

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### Section A — Insurer Group Information (This section must be completed.)

This section identifies the Insurers within the NAIC Group that will be reporting under the specified Insurer Group. List all Insurers that will generate California MDC records for the Insurer Group, including those Insurers that may not be domiciled in California, if those records will be included in California MDC submissions.

Insurer Group Name _____ Insurer Group Code _____

**Insurer Group Members**

| | NCCI Carrier Code | Insurer Name |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
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| 18. | | |
| 19. | | |
| 20. | | |

### Submitter Count (This section must be completed for new Insurer Groups.)

Indicate the number of Insurer Group members that will be Submitters reporting on behalf of the Insurer Group. _____



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wcirb.com

Insurer Group Name

## Section B — Insurer Group Contact Information

This section must be completed for new Insurer Groups or for changes to existing Insurer Group Contact Information.

**Check One:** ☐ **New Insurer Group** ☐ **Change to Insurer Group Contact Information**

### Legal Contact

The Legal Contact must be an officer or attorney who is authorized to accept legal notices on behalf of each Insurer within the Group.

Contact Name | Title

Company

Address

City | State | Zip

Telephone | Fax | Email (required)

### Primary Contact

The Primary Contact is a person with whom the WCIRB will communicate regarding the registration process.

Contact Name | Title

Company

Address

City | State | Zip

Telephone | Fax | Email (required)

### Secondary Contact

The Secondary Contact is a person with whom the WCIRB will communicate regarding the registration process.

Contact Name | Title

Company

Address

City | State | Zip

Telephone | Fax | Email (required)

Receive Medical Data Call reports and file status communications via email? ☐ Yes ☐ No



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Insurer Group Name

## Insurer Signatory(ies)

The Signatory(ies) must be an officer or attorney affiliated with each Insurer who is authorized to legally bind each Insurer and is authorized to sign the MDC Agreement on behalf of each Insurer in the Insurer Group. If there are multiple Signatories, please list each and the Insurer for which they are authorized to sign the MDC Agreement.

☐ Check here if the Signatory is authorized to sign the MDC Agreement on behalf of all Insurers in the Insurer Group. If required, list Additional Signatories on the last page of this form.

Contact Name | Title

Company(ies)

Address

City | State | Zip

Telephone | Fax | Email (required)

Contact Name | Title

Company(ies)

Address

City | State | Zip

Telephone | Fax | Email (required)

Contact Name | Title

Company(ies)

Address

City | State | Zip

Telephone | Fax | Email (required)



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Insurer Group Name

## Section C — Submitter Contact Information and Insurer List

Please complete Part 1 of Section C for each Submitter. If only one Submitter will report data on behalf of your company, then only one copy of Section C is needed. If more than one Submitter will report data on behalf of your company, you must complete Part 1 of Section C for each additional Submitter who is submitting for All Insurers in Insurer Group (if submitting for a subset of Insurers in this Insurer Group, complete Part 2 below). You may use this form to submit information for up to 5 Submitters. Unused pages may be left blank.

### Part 1 Submitter Contact Information

Indicate whether the Submitter is a Third Party Entity (TPE) or an Insurer within the Insurer Group. ☐ Insurer ☐ TPE

Submitter Company Name

Submitter Address

City State Zip

Federal Employer Identification Number

Reporting Medium: ☐ CDX ☐ Direct FTP

### Submitter Medical Data Call Primary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

### Submitter Medical Data Call Secondary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

Receive Medical Data Call reports and file status communications via email? ☐ Yes ☐ No



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Insurer Group Name

## Section C — Submitter Contact Information and Insurer List

### Part 2 Supplemental Insurer List

List all Insurers that will generate California Medical Data Call records for the Insurer Group that the Submitter listed directly above will be submitting.

Check One: ☐ Submitting for All Insurers in the Insurer Group

☐ Submitting for the subset of Insurers within the Insurer Group identified below

| | Insurer Name | NCCI Carrier Code | Policy Effective Date Range (If Applicable) |
|---|---|---|---|
| 1. | | | |
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| 3. | | | |
| 4. | | | |
| 5. | | | |
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Insurer Group Name

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### Part 1 Submitter Contact Information

Indicate whether the Submitter is a Third Party Entity (TPE) or an Insurer within the Insurer Group. ☐ Insurer ☐ TPE

Submitter Company Name

Submitter Address

City State Zip

Federal Employer Identification Number

Reporting Medium: ☐ CDX ☐ Direct FTP

### Submitter Medical Data Call Primary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

### Submitter Medical Data Call Secondary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

Receive Medical Data Call reports and file status communications via email? ☐ Yes ☐ No



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### Part 1 Submitter Contact Information

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Submitter Company Name

Submitter Address

City State Zip

Federal Employer Identification Number

Reporting Medium: ☐ CDX ☐ Direct FTP

### Submitter Medical Data Call Primary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

### Submitter Medical Data Call Secondary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

Receive Medical Data Call reports and file status communications via email? ☐ Yes ☐ No



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Submitter Company Name

Submitter Address

City State Zip

Federal Employer Identification Number

Reporting Medium: ☐ CDX ☐ Direct FTP

### Submitter Medical Data Call Primary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

### Submitter Medical Data Call Secondary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

Receive Medical Data Call reports and file status communications via email? ☐ Yes ☐ No



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### Part 1 Submitter Contact Information

Indicate whether the Submitter is a Third Party Entity (TPE) or an Insurer within the Insurer Group. ☐ Insurer ☐ TPE

Submitter Company Name

Submitter Address

City State Zip

Federal Employer Identification Number

Reporting Medium: ☐ CDX ☐ Direct FTP

### Submitter Medical Data Call Primary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

### Submitter Medical Data Call Secondary Contact

Submitter Contact Name Title

Submitter Address

City State Zip

Telephone Fax Email (required)

Receive Medical Data Call reports and file status communications via email? ☐ Yes ☐ No



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Insurer Group Name

### Section C — Submitter Contact Information and Insurer List

#### Part 2 Supplemental Insurer List

List all Insurers that will generate California Medical Data Call records for the Insurer Group that the Submitter listed directly above will be submitting.

Check One: ☐ Submitting for All Insurers in the Insurer Group

☐ Submitting for the subset of Insurers within the Insurer Group identified below

| | Insurer Name | NCCI Carrier Code | Policy Effective Date Range (If Applicable) |
|---|---|---|---|
| 1. | | | |
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## Insurer Group Profile and Contact Designation

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Insurer Group Name

### Additional Insurer Signatory(ies) (If needed)

Contact Name | Title

Company(ies)

Address

City | State | Zip

Telephone | Fax | Email (required)

Contact Name | Title

Company(ies)

Address

City | State | Zip

Telephone | Fax | Email (required)

Contact Name | Title

Company(ies)

Address

City | State | Zip

Telephone | Fax | Email (required)

Contact Name | Title

Company(ies)

Address

City | State | Zip

Telephone | Fax | Email (required)



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