# Instructions for

# Akos Registration Form

This form must be completed by the sales agent whenever a new group client is onboarded and the client is expected to enroll employees/members in Primary or Optimal Care plans.

Tips

- The fields on the form are small, it would be helpful to enlarge the form using your .PDF reader software before filling in the fields.
- The fields outlined in red are required input fields

Completing the Form

- If your new group is self-insured and will continue to provide their self-insurance coverage after enrollment with Optimal teleHealth, contact Optimal telehealth before completing this form.
- The fields under "Preferred Providers, Facilities or Direct Contracts are generally related to self-insured companies, but if the group has such relationships they prefer their employees use, then provide their names
- Under the "Cost Containment" header, if the group will be enrolling employees in Optimal Care, the 2nd Opinion Program will be "2nd MD"

What Next?

- Upon completion, forward to Larry.Stout@OptimalteleHealth.com
- Don't bother to get it signed, it will be sent to the group contact person along with the Akos services agreement to be eSigned. Upon execution, Optimal teleHealth will forward the documents to Akos MD. Akos will counter-sign and return copies to Optimal teleHealth.

akos
remedies in real time
AkosMD.com
1.844.900.AKOS
PO Box 41638 Phoenix, AZ 85080

# Client Implementation Form

| Company Information | | | |
|---|---|---|---|
| Company Name: | | Phone Number: | |
| Address: | | City, State, Zip: | |
| Email Address: | | Standard Industry Code (SIC): *Required only if self insured* | |
| Federal Tax ID: *Required only if self insured* | | Total # of Employees: | |
| Nature of Business: | | | |
| Requested Effective Date: | | Open Enrollment Dates: | **N/A** |
| **Advisor/Broker Information** | | | |
| Name: | | Company: | Optimal teleHealth, LLC |
| Phone Number: | | Email Address: | |
| **Employer Group Contact Information** | | | |
| Name: | | Title: | |
| Phone Number: | | Email Address: | |
| Address: | | City, State, Zip: | |
| **Billing Information to Send Invoices** | | | |
| Name & Organization: | | Phone Number: | |
| Address: | | City, State, Zip: | |
| Census provided by: (name & organization) | Optimal teleHealth, LLC | | |
| **Health Plan Information** | | | |
| Is Employer Self-Insured: | | ***If yes, answer below*** | |

| | | | |
|---|---|---|---|
| TPA: | | PBM: | |
| TPA Contact Name: | | PBA Contact Name: | |
| Phone Number: | | Phone Number: | |
| Email Address: | | Email Address: | |
| Stop Loss Carrier: | | Provider Network / RBP Vendor: | |
| Stop Loss Contact Name: | | Network / RBP Contact Name: | |
| Phone Number: | | Phone Number: | |
| Email Address: | | Email Address: | |
| Is the Employer Fully Insured? | | Network: | |
| Carrier Name: | | Medical Cost Share Organization: | **Sedera** |
| Is the Employer offering Medical Cost Sharing? | **Yes** | | |
| **Preferred Providers, Facilities or Direct Contracts** | | | |
| Imaging: | | Laboratories: | |
| Urgent Care: | | Hospital System: | |
| **Cost Containment** | | | |
| Bill Negotiation: | **My Telemedicine, Inc.** d/b/a Lyric Health | Patient Advocacy: | **My Telemedicine, Inc.** d/b/a Lyric Health |
| Specialty Pharmacy: | | 2nd Opinion Program: | |

| Akos VPC Membership Choice | |
|---|---|
| VPC | ☒ |
| VPC Plus | ☐ |
| Telemedicine | N/A |

**Special Notes / Instructions:

| Sold Rates | | | |
|---|---|---|---|
| | **VPC** | **VPC+** | **Telemedicine** |
| Employee (EE) | **$ 25** | **$ 48** | **$ N/A** |
| Employee/Spouse (ES) | **$ 50** | **$ 72** | **$ N/A** |
| Employee/Child(ren) (EC) | **$ 56** | **$ 84** | **$ N/A** |
| Family (F) | **$ 75** | **$ 98** | **$ N/A** |

_____ _____

*Signature* *Date*

_____ _____

*Printed Name* *Organization*