

## Managed Care Network Evaluation Form

Insured Name: \_\_\_\_\_

Insured Location(s) \_\_\_\_\_

Proprietary Network: \_\_\_\_\_

Anticipated Savings for: Inpatient Hospital \_\_\_\_\_  
Outpatient Hospital \_\_\_\_\_  
Physicians Charges \_\_\_\_\_  
Ancillary Charges \_\_\_\_\_

# of Network Hospitals: \_\_\_\_\_

# of Network Physicians: \_\_\_\_\_

% of Group Participation: \_\_\_\_\_

National Network: \_\_\_\_\_

Anticipated Savings for: Inpatient Hospital \_\_\_\_\_  
Outpatient Hospital \_\_\_\_\_  
Physicians Charges \_\_\_\_\_  
Ancillary Charges \_\_\_\_\_

# of Network Hospitals: \_\_\_\_\_

# of Network Physicians: \_\_\_\_\_

% of Group Participation: \_\_\_\_\_

Other Network: \_\_\_\_\_

Anticipated Savings for: Inpatient Hospital \_\_\_\_\_  
Outpatient Hospital \_\_\_\_\_  
Physicians Charges \_\_\_\_\_  
Ancillary Charges \_\_\_\_\_

# of Network Hospitals: \_\_\_\_\_

# of Network Physicians: \_\_\_\_\_

% of Group Participation: \_\_\_\_\_

Signed By: \_\_\_\_\_

Date: \_\_\_\_\_