



HEALTHCARE AUDIT REWARD PROGRAM (HARP)

In this day of high health care costs, it is very important that we become better health care consumers. We need to be better informed, ask more questions and take a more active role in helping to contain the high cost of health care.

Effective March 1, 2001, Michigan Technological University employees will be able to share in the savings from any indentified errors on your health or dental Explanation of Benefits (EOB) form. An EOB is a statement summary and is sent by AETNA to your home (or online) when services have been submitted by your provider for payment. Remember, since you are the patient, you are the one that really knows what has occurred.

Some of the items to watch for include:

- **date of service – is it correct?**
- **service – was the service actually done?**
- **name of patient or provider – is it correct?**

Each time your efforts lead to a corrected EOB and the error would have resulted in an overpayment, you will received 35% of the benefit overpayment that would have been made. There is a minimum reward of \$5.00 and a \$500.00 maximum reward if you can determine an error was made. This reward is considered taxable income to you.

If you find an error in your EOB, print off the HARP form that is on this link, it will outline the steps and procedures you will need to follow.

If you have any questions, please call the Benefits office at 906-487-2517 or email the Renee Hiller at rhiller@mtu.edu.



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Employee Name: _____

Employee ID Number: _____

Department: _____

Daytime Telephone Number: _____

Patient's Name: _____ Date of Service: _____

Name of the Provider/Physician: _____

Please identify the type of service provided:

Physician Office Visit

Vision

Inpatient Hospital Stay

Dental

Outpatient Services including Lab & X-ray

Other _____

In the space below, please describe the error you identified on the EOB:

You are required to contact the service provider **AND** Aetna to discuss the error. Please provide the date of the call, name of the person contacted, and the resulting discussion.

Service Provider contacted: _____ Person Contacted: _____
(Date)

Resulting discussion: _____

Aetna contacted _____ Person Contacted: _____
(Date)

Resulting discussion: _____

****Please attach a copy of the Explanation of Benefits (EOB) to this form and return to the Benefits office. This form will be returned to you if any part is incomplete or if the EOB is not attached.**

Employee Signature

Date