APPLICATION TRACKING NUMBER:_____ (FOR OFFICE USE ONLY)

HEALTH MAINTENANCE ORGANIZATIONS
AND
PREPAID HEALTH CLINICS

APPLICATION FOR HEALTH CARE PROVIDER CERTIFICATE

Pursuant to Chapter 641, Part III, Florida Statutes, and Chapter 59A-12 of the Florida Administrative Code, application is hereby made for a Health Care Provider Certificate.

I. APPLICATION INFORMATION

Application is for: (check one in each column)

- ☐ Initial Certification
- ☐ Renewal Certification
- ☐ Name Change

- ☐ HMO
- ☐ PHC

II. ORGANIZATION IDENTIFICATION

Legal Name of Organization _____

Address _____
Street County

_____
City State Zip Code

Federal ID Number _____

Mailing address (if different from above address):

_____
Address P.O. Box

_____
City State Zip Code

Telephone number (_____) _____ FAX number (_____) _____

III. IDENTIFICATION OF PRINCIPAL FILING THIS APPLICATION

Name _____

Position or Title _____

Address_____
Street County

_____
City State Zip Code

Telephone number (_____) _____ FAX number (_____)_____

IV. IDENTIFICATION OF CONTACT PERSON(S)

Name _____

Position or Title _____

Address _____
street county

_____
city state zip code

Telephone number (_____) _____ FAX number (_____) _____

V. IDENTIFICATION OF NETWORK

A. Subscriber Enrollment. It is understood that the method of subscriber enrollment may impact compliance with access timeframes to the provider network. It is therefore the intent of this organization to enroll subscribers based upon:

- ☐ Subscriber's county of residence
- ☐ Subscriber's county of employment
- ☐ Both of the above

B. Network Composition. It is understood that if an organization offers different insurance products that require the utilization of different provider networks, each network must be approved by the agency. Indicate the following:

	No	Yes
Will more than one network be utilized? (identify and explain)	☐	☐

	No	Yes
Are there any restrictions/limitations to subscriber access? (identify and explain)	☐	☐

VI. APPLICATION FEE

A check in the amount of **one thousand dollars ($1,000.00)** must be attached, payable to the AGENCY FOR HEALTH CARE ADMINISTRATION.

VII. ENCLOSURES

Enclose the items listed below with this application. Renewal applications require a statement of no change; otherwise submit only those items that have been changed or amended since the previous application.

Please submit enclosures on 8 1/2" x 11" paper rather than legal paper.

A. If applicant is a partnership or association, provide the full name, address, and title of each member.

B. If applicant is a corporation, provide a list of the names, addresses, and official capacities within the organization of the persons who are to be responsible for the conduct of the affairs of the organization, including all officers and directors of the corporation. Such persons shall fully disclose to the agency and the directors of the organization the extent and nature of any contracts or arrangements between them and the health maintenance organization or the prepaid health clinic, including any possible conflicts of interest. Include a listing of corporate and regional medical directors and grievance coordinators, with both mailing and street addresses, phone numbers, and fax numbers, as applicable.

C. A copy of the articles of incorporation and all amendments thereto. (i.e. name changes, mergers, and acquisitions require resubmission of this enclosure).

D. A statement generally describing the organization and its operation.

E. A statement describing the manner in which health care services shall be regularly available. Include the type of organization (i.e., staff model, IPA model, mixed model.

F. A statement that the applicant has an established network of health care providers which is capable of providing the health care services that are to be offered by the

organization. Identify any executed contracts between the organization and other parties for the provision of a provider network. Include any arrangements made for delegated responsibilities (i.e., quality assurance, utilization review, case management, and credentialing) and oversight.

G. A statement giving the present and projected number of subscribers to be enrolled yearly for the next three years. This statement should provide numbers by county and product (i.e., Commercial, Medicaid, Medicare, etc.).

H. A statement and scaled map describing with reasonable accuracy the specific geographic area to be served.

I. Include a copy of the letter from the Department of Financial Services accepting the receipt of an application for a Certificate of Authority submitted by the organization (initial applications only).

VIII. ITEMS FOR REVIEW AT FACILITY FOR INITIAL APPLICATIONS

The following items shall be available for review at the facility when the department conducts an examination of the organization:

A. A copy of the bylaws, rules and regulations, or similar form of document, regulating the conduct of the affairs of the applicant;

B. A copy of the form for each group and individual contract, certificate, subscriber handbook, and any other similar documents issued to subscribers;

C. The type of health care personnel engaged to provide the health care services and the quantity of the personnel of each type;

D. A statement indicating the source of emergency services and care on a twenty-four hour basis;

E. A statement that the physicians employed by the applicant have been formally organized as a medical staff and that the applicant's governing body has designated a chief of medical staff.

F. A statement describing the manner in which the organization assures the maintenance of a medical records system in accordance with accepted medical records' standards and practice;

G. If general anesthesia is to be administered in a facility not licensed by the agency, a copy of architectural plans to meet the requirements for institutional occupancy (NFPA 101 Life Safety Code, current edition as adopted by the State Fire Marshal);

H. A description of the organization's quality assurance program, including committee structure, criteria and procedures for corrective action which complies with s. 641.51, F.S.;

I. A description and supporting documentation concerning how the applicant will comply with the internal risk management program requirements as required under s. 641.55, F.S.;

J. An explanation of how coverage for emergency services and care is to be effected outside the health maintenance organization's stated geographic area.

K. The location of the facilities at which health care services shall be regularly available to subscribers. The listing should indicate the name, address, telephone number and specialty of all contracted primary care physicians, specialty physicians, ancillary services and hospital facilities and should be grouped by county. In addition, complete the provider checklist (AHCA Form 3160-1003) for each county. Submit any executed contracts between the organization and other parties for the provision of a provider network. Include a copy of the contract for any subcontracted services and those provider directories. Also note any access restrictions to the contracted network of providers. Include a scale map(s) of each service area which shows the location of primary care physicians, specialty physicians, hospitals, and applicable ancillary services. The boundary of the service area should be within 30 minutes average travel time for primary care physicians and hospitals, and within 60 minutes for specialty physicians.

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

IX. SERVICE AREA

INITIAL:

____Alachua	____Flagler	____Lake	____Pinellas
____Baker	____Franklin	____Lee	____Polk
____Bay	____Gadsden	____Leon	____Putnam
____Bradford	____Gilchrist	____Levy	____Santa Rosa
____Brevard	____Glades	____Liberty	____Sarasota
____Broward	____Gulf	____Madison	____Seminole
____Calhoun	____Hamilton	____Manatee	____St. Johns
____Charlotte	____Hardee	____Marion	____St. Lucie
____Citrus	____Hendry	____Martin	____Sumter
____Clay	____Hernando	____Monroe	____Suwannee
____Collier	____Highlands	____Nassau	____Taylor
____Columbia	____Hillsborough	____Okaloosa	____Union
____Dade	____Holmes	____Okeechobee	____Volusia
____DeSoto	____Indian River	____Orange	____Wakulla
____Dixie	____Jackson	____Osceola	____Walton
____Duval	____Jefferson	____Palm Beach	____Washington
____Escambia	____Lafayette	____Pasco	

RENEWALS: (Place the date (mm/yy) of approval next to the county name)

(Use the "Enter" key NOT the "Tab" Key to move around the counties.)

____Alachua	____Flagler	____Lake	____Pinellas
____Baker	____Franklin	____Lee	____Polk
____Bay	____Gadsden	____Leon	____Putnam
____Bradford	____Gilchrist	____Levy	____Santa Rosa
____Brevard	____Glades	____Liberty	____Sarasota
____Broward	____Gulf	____Madison	____Seminole
____Calhoun	____Hamilton	____Manatee	____St. Johns
____Charlotte	____Hardee	____Marion	____St. Lucie
____Citrus	____Hendry	____Martin	____Sumter
____Clay	____Hernando	____Monroe	____Suwannee
____Collier	____Highlands	____Nassau	____Taylor
____Columbia	____Hillsborough	____Okaloosa	____Union
____Dade	____Holmes	____Okeechobee	____Volusia
____DeSoto	____Indian River	____Orange	____Wakulla
____Dixie	____Jackson	____Osceola	____Walton
____Duval	____Jefferson	____Palm Beach	____Washington
____Escambia	____Lafayette	____Pasco	

X. AFFIDAVIT

I, _____, hereby swear (or affirm) that I have been authorized by the governing body of the aforementioned organization to file this application and that the statements in this application are true and correct to the best of my knowledge and belief.

_____ _____
Name (please print) Signature

_____
Title

_____ _____
Name (please print) Signature

_____
Title

Subscribed and sworn to before me this _____ day of _____, _____.

_____
Notary Public, State of Florida

Personally known ___; or ID Produced ___; Type of ID Produced _____

XI. INSTRUCTIONS

I. Application Information. Please place a check before the type of agency action which is being requested by the applicant.

II. Organization Identification. List the legal name of the applicant as registered with the Department of State.

III. Identification of Principal Filing this Application. List the name, position, phone number, mailing address and telephone number of the designated individual who has the authority to bind the organization.

IV. Identification of Contact Person(s). List the name, position, phone number, mailing address and telephone number of the designated individual employed by or representing the applicant who will be responsible for responding to the agency on behalf of the applicant.

V. Identification of Network. Place a check mark next to the method of subscriber enrollment. Place a check mark next to the appropriate composition statement; if the answer is "yes", identify each network. Explain any subscriber access restrictions or limitations.

VI. Application Fee. For initial and renewal applications attach a check for $1,000 made out to the Agency for Health Care Administration.

VII. Enclosures. Submit enclosures on 8 1/2" x 11" paper rather than legal paper.

VIII. Items for Review at Facility for Initial Applications.

IX. Service Area. Place a check mark next to each county in which the applicant is requesting certification as an initial HMO or PHC. Only check as many or as few counties as you wish to justify as having a comprehensive network of services. Also indicate applicable limitations of service area (excluded zip codes), if any. If this is a renewal, indicate the date on which each county was approved.

X. Affidavit. Notarized signatures of two individuals who have the authority to bind the organization.

XI. Instructions. Complete the application as specified above and submit two (2) copies of the application with all required enclosures, together with your check to: Agency for Health Care Administration, Bureau of Managed Health Care - Network Services Unit, 2727 Mahan Drive, Mail Stop Code 26, Tallahassee, Florida 32308-5403
Telephone: 850-487-0640.