EXCLUSIVE PROVIDER ORGANIZATION APPLICATION

Pursuant to section 627.6472, Florida Statutes, application is hereby made to offer a health insurance policy or certificate subject to an exclusive provider provision.

I. ORGANIZATION IDENTIFICATION

Name of organization ____

Address ____
Street City

Mailing Address (if different from above address):

____
Street Address P.O. Box

____

Telephone Number (______) _________-________ Fax Number (______) ________-___________

____
Street P.O. Box

____
City State Zip

Federal Identification Number ____

II. IDENTIFICATION OF PRINCIPAL FILING THIS APPLICATION

Name ____

Position or Title ____

Address ____
Street City

____
County State Zip

Mailing Address (if different from above address)

____
Street P.O. Box

____
City State Zip

Telephone number (______)-______-________ Fax Number (______) ________-___________

III. IDENTIFICATION OF CONTACT PERSON (S) IN FLORIDA

Name ____

Position or Title ____

Address ____
Street City

____
County State Zip

Telephone number (_______) _______-________ Fax Number (______) ________-___________

IV. LICENSING INFORMATION

Is the organization licensed in the State of Florida as an insurance company? Yes____ No____.
If yes, provide the license number issued by the Florida Department of Insurance.

____
Certificate of Authority Number

V. INFORMATION REQUIRED TO BE SUBMITTED AS ATTACHMENTS

A. Provide documentation that the number of exclusive providers in the service area is sufficient with respect to current and expected policyholders, either to deliver adequately all services that are subject to an exclusive provider provision or to make appropriate referrals.

B. Provide documentation that there are written agreements with exclusive providers describing specific responsibilities.

C. Provide documentation that emergency care is available 24 hours a day 7 days a week.

D. Provide documentation that in case of covered services that are subject to an exclusive provider provision, there are written agreements with exclusive providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any policyholders. This does not apply to supplemental changes or coinsurance amounts stated in the policy or certificate

E. Submit a statement or map providing a clear description of the service area.

F. Provide a detail description of the grievance procedure to be used.

G. Provide a description of the quality assurance program, include all of the following:

1. The formal organizational structure.

2. The written criteria for selection, retention and removal of exclusive providers.

3. The procedures for evaluating quality of care provided by exclusive providers, and the process to initiate corrective action when warranted.

H. Submit a list and description by specialty, of the exclusive providers.

I. Submit the written information proposed to be used by the insurer to comply with subsection 627.6472 (10). This subsection reads as follows:

(10) An insurer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the policy or certificate to each policyholder and certificate holder, including at least the following:

(a) A description (including address and phone number) of the exclusive providers, including primary care physicians, specialty physicians, hospitals, and other providers.

(b) A description of the exclusive provider provisions, inclusion coinsurance and deductible levels if providers other than exclusive providers are used.

(c) A description of coverage for emergency and urgently needed care and other out of service area coverage.

(d) A description of limitations on referrals to restricted exclusive providers and to other providers.

(e) A description of the insurer's quality assurance program and grievance procedure.

J. Submit a statement giving the projected number of subscribers to be enrolled yearly for the next three years.

K. Will the insurer utilize a health maintenance organization provider network to provide health care to the EPO subscribers? Yes____ No_____.
If yes, provide name(s) and address(s) of the HMO:

____
Name of HMO

____
Address of HMO

____

VI. AFFIDAVIT

I, ____, hereby swear (or affirm) that the statements in this application are true and correct to the best of my knowledge and belief.

Subscribed and sworn to before me this ________ day of _____________, 19___.

_________________________________	_____________________________________
Notary Public	Name (please type)
	_____________________________________
	Title
	_____________________________________
	Signature

Personally known _____; or ID Produced ______;
Type of ID Produced ______________________

VII. INSTRUCTIONS

Submit two copies of the application with all required enclosures to:

Agency for Health Care Administration
Bureau of Managed Health Care
2727 Mahan Drive, Building 1, Mail Stop 26
Tallahassee, Florida 32308
(850) 487-0640