

RHODE ISLAND DEPARTMENT OF HEALTH
Application for Health Plan Certification / Re-certification*

Name of health plan applicant: _____

Total Rhode Island health plan enrollment: _____

Application for new certification Application for re-certification, if so:
Current certificate #: _____

Name of health care entity: _____

d/b/a in Rhode Island: _____

Name of health plan's President/C.E.O.: _____

Application contact: _____ Title: _____

Application address: _____

Phone: (____) _____ FAX: (____) _____

Applicant E-mail address: _____

Billing contact: _____ Title: _____

Billing address: _____

Phone: (____) _____ FAX: (____) _____

Billing E-mail address: _____

Ownership of health care entity:

- Individual Partnership Corporation

Provide a list with the names and addresses of all direct and indirect owners whether individual, partnership or corporation with percent ownership. The list shall also include all officers, directors, and other persons of any subsidiary corporation owning stock, if the health care entity is organized as a corporation or all partners, if the health care entity is organized as a partnership.

Brief description of health plan:

Provide a description of the type/structure of the health plan (e.g., discounted fee-for-service, ASO, PPO, HMO, etc.); services/benefits provided & to whom (describe population); risk-sharing arrangements with providers; and any financial incentives available to enrollees:

Does health plan perform its own utilization review? Yes No

If no, provide a signed copy of the delegation contracts/agreements for each agency that performs utilization review for the health plan.

Are any other health plan services contracted out, carved out, or delegated to another organization? Yes No

If yes, provide a signed copy of the delegation contracts/agreements for each health plan service that is delegated (e.g., mental health, substance abuse, pharmacy, vision, dental, etc.).

All supporting documents are required in accordance with the *Health Plan Application Guidelines*:

- ◆ **I. Application Information for Each Health Plan Applicant: TAB A**
- ◆ **II. Consumer Disclosure Information: TAB B**
- ◆ **III. Policies and Procedures: TAB C - J**
- ◆ **IV. Contract Elements: TAB K**

Please enclose the non-refundable health plan application fee of \$500 made payable by check to the “General Treasurer, State of Rhode Island.”

I hereby submit this application with the attached *Assurances* and supporting documents, as required under RIGL 23-17.13, which contain true and accurate information to the best of my knowledge and belief.

Signature of person authorized by the health plan to submit this application:

Signature: _____

Title: _____ **Date:** _____

State of (.....)
County of (.....)
In....., *in said county on this*.....*day of*.....*A.D.*
20....., *personally appeared before me*.....
Of..... *who, after signing the foregoing ownership*
report in my presence, made oath that the facts stated in said report are true.

NOTARY PUBLIC

*Please do not re-format the *Application for Health Plan Certification / Re-certification* form.

RHODE ISLAND DEPARTMENT OF HEALTH

Application for Health Plan Certification / Re-certification

Assurances*

Citations refer to the *Rules and Regulations for the Certification of Health Plans (R23-17.13-CHP)* (herein HP).

I am aware of Chapter 23-17.13 of the General Laws of the state of Rhode Island, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of health plans. If certification is granted, I, for and on behalf of the health plan applicant, hereby bind the health plan and agree to the following:

1. To comply with all statutory and regulatory requirements.
2. To adhere to any and all applicable state and federal laws.
3. That all policies/procedures presented in this application for health plan certification are approved by the governing body/CEO, and have been or will be implemented and incorporated into the applicant's operations throughout the certification period unless modified according to section 2.5.
4. The health plan will disclose to prospective and current enrollees the information as defined and required by section 4 and Appendix "A."
5. Notification of any proposed, systemic change to the attached health plan certification application information, or that information on file at the Rhode Island Department of Health (Department) related to the health plan, will be provided to the Department. If the Department does not disapprove of the modification within ninety (90) days of the receipt of all necessary information, the modification shall be deemed approved. [HP 2.4, 2.5]
6. The health plan will not refuse to contract with, or compensate for covered benefits, an otherwise eligible provider or non-participating provider solely because that provider has in good faith communicated with one or more of his/her patients regarding the provisions, terms, or requirements of the health plan, as they relate to the needs of that provider's patient. [HP 5.1]
7. The health plan will not terminate any physician/other provider contract(s) "without cause". [HP 5.3]
8. The health plan will not enter into any compensation agreement with any provider of covered services or pharmaceutical manufacturer pursuant to which specific payment is made directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient. [HP 5.4]
9. The health plan will publicly notify professional providers within the health plan's geographic service area of the opportunity to apply for credentials when the health plan contemplates adding providers according to R23-17.13. [HP 5.6]
10. The health plan will not exclude a professional provider of covered benefits from participation in its provider network based solely on the professional provider's degree or type of license as applicable under state law; or the lack of affiliation with, or admitting privileges at a hospital, if such lack of affiliation is due solely to the professional providers' type of license. [HP 5.8]
11. The health plan will not discriminate against providers solely because the provider treats a substantial number of patients who require expensive or uncompensated medical/health care. [HP 5.9]
12. The health plan will not include a most favored rate clause in a provider contract, and any most favored rate clause included in any provider contract will be null and void on and after January 1, 2003. [HP 5.15]

13. As applicable, the health plan will comply with the *Rules and Regulations for the Utilization Review of Health Care Services* pursuant to Chapter 23-17.12 of the General Laws of Rhode Island as amended.
14. The health plan will provide reports and information required on forms prescribed by the Department to determine if the health plan is in compliance with the provisions of Chapter 23-17.13 of the General Laws of Rhode Island, as amended. Required quarterly reports will be submitted to the Department sixty (60) days after the end of each quarter of the calendar year. Required annual reports will be submitted to the Department ninety (90) days after the end of each calendar year. [HP 8.1]

Signature of person authorized by the health plan to provide the above assurances in connection with the health plan's application:

Signature: _____

Title: _____ **Date:** _____

For the Health Plan Named: _____

State of (.....)

County of (.....)

In....., *in said county on this*.....*day of*.....*A.D.*

20....., *personally appeared before me*.....

Of..... *who, after signing the foregoing ownership report in my presence, made oath that the facts stated in said report are true.*

NOTARY PUBLIC

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Rhode Island Department of Health
3 Capitol Hill, Providence RI, 02908-5097
MANDATORY ADDENDUM TO LICENSE APPLICATION
Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the Tax Administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # _____)
- I am in state receivership. (Case # _____)
- I have been discharged from Bankruptcy.
(Case # _____)

Type of Professional/Business License for which you are applying

Full Name (Please Print or Type)

Social Security Number (or FEIN for Business)

Signature

Phone Number (including area code if not 401)

Date

Name of Business (If Applicable)

This form must be completed, signed and attached to your license application for processing.