APPLICATION FOR HEALTH CARE PROVIDER CERTIFICATE

Health Maintenance Organizations (HMOs) and Prepaid Health Clinics (PHCs)

Applicants **must** comply with Section 641.495, Florida Statutes (F.S.) - **Requirements for issuance and maintenance of certificate;** Section 59A-12.003, Florida Administrative Code (F.A.C.) - **Administration, Forms, Fees;** and Section 59C-1.022, Florida Administrative Code (F.A.C.) **- Health Care Facilities Fee Assessments and Fee Collection Procedures** in order to obtain a Health Care Provider Certificate.

Upon receipt of an Application for Health Care Provider Certificate (HCPC) from a Health Maintenance Organization (HMO) or Prepaid Health Clinic (PHC), the Agency for Health Care Administration (AHCA) shall review the submission for completeness and accuracy. Within thirty (30) days of receipt, AHCA will notify the applicant of any apparent errors or omissions and request any additional information required. Applicants must provide the requested information within twenty-one (21) days of AHCA's notice; failure to do so will result in the application being deemed incomplete and withdrawn from further consideration. Following receipt of all required information, AHCA shall approve or deny the application within ninety (90) days. Applications for renewal of a Health Care Provider Certificate must be submitted no later than ninety (90) days prior to the expiration of the current certificate.

APPLICATION INSTRUCTIONS

In order to process the application in a timely manner, you must submit a **completed** application **and** all of the supporting documentation as required by Chapter 641 Part III, F. S. and Chapter 59A-12, F.A.C. electronically.

Please do not submit paper documents.

The following fees are required to process initial and renewal applications:

- **Initial and Renewal Application Fee submitted with the application-** $1000
- **Biennial Assessment Fee submitted with the application renewal or within 20 days of initial issue of the HCPC–** $300

Make checks payable to the **Agency for Health Care Administration**, include the applicant's plan name on the check(s) to ensure proper credit and mail the check(s) to the address below:

Commercial Managed Care Unit
Agency for Health Care
Administration 2727 Mahan Drive,
Mail Stop #28
Tallahassee, FL 32308

Applications for **NAME CHANGE** require only the completion of **sections II, III, IV and VIII**. There is no associated fee.

I. APPLICATION INFORMATION

Type: (check one) ☐ Initial Certification ☐Renewal Certification ☐Name Change

Provider Type: (check one)	**Product Line(s) of Business: (check all that apply)**	**Practice Model: (check if applicable)**
☐ HMO	☐ Commercial	☐ Individual Practice Association (IPA) Model
☐ PHC	☐ Medicare	☐ Staff Model
	☐ Medicaid	☐ Mixed (both IPA & Staff Model)
	☐ Florida Healthy Kids	

II. ORGANIZATION IDENTIFICATION

Legal Name of Organization	**Federal ID Number**	
Street Address		
City	**State**	**ZIP Code**
Telephone Number	**Website**	
Mailing Address (if different)		
City	**State**	**ZIP Code**

III. PRINCIPAL FILING THE APPLICATION *(This person must have the authority to bind the organization.)*

Name	**Official Capacity**	
Street Address		
City	**State**	**ZIP Code**
Telephone Number	**Email Address**	
Mailing Address (if different)		
City	**State**	**ZIP Code**

IV. CONTACT PERSON *(This person will communicate with the Agency regarding the application.)*

Name	**Official Capacity**	
Street Address		
City	**State**	**ZIP Code**
Telephone Number	**Email Address**	
Mailing Address (if different)		
City	**State**	**ZIP Code**

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.
Please answer the following questions:

Will more than one network be utilized? ☐NO ☐YES
(If yes, identify and explain.)

Are there any restrictions or limitations to subscriber access? ☐ NO ☐YES
(If yes, identify and explain.)

VI. SERVICE AREA *(Check each service area by product line of business being requested **or** renewed.)*

C=Commercial **M=Medicare** **MEDICAID: ST=Standard, SPC=Specialty, LTC=Long Term Care** **FHK=Florida Healthy Kids**

			MEDICAID							MEDICAID			
COUNTY	C	M	ST	SPC	LTC	FHK	COUNTY	C	M	ST	SPC	LTC	FHK
Alachua	☐						Lee						
Baker	☐						Leon						
Bay	☐						Levy						
Bradford	☐						Liberty						
Brevard	☐						Madison						
Broward	☐						Manatee						
Calhoun	☐						Marion						
Charlotte	☐						Martin						
Citrus	☐						Miami-Dade						
Clay	☐						Monroe						
Collier	☐						Nassau						
Columbia	☐						Okaloosa						
DeSoto	☐						Okeechobee						
Dixie	☐						Orange						
Duval	☐						Osceola						
Escambia	☐						Palm Beach						
Flagler	☐						Pasco						
Franklin	☐						Pinellas						
Gadsden	☐						Polk						
Gilchrest	☐						Putnam						
Glades	☐						Santa Rosa						
Gulf	☐						Sarasota						
Hamilton	☐						Seminole						
Hardee	☐						St. Johns						
Hendry	☐						St. Lucie						
Hernando	☐						Sumter						
Highlands	☐						Suwannee						
Hillsborough	☐						Taylor						
Holmes	☐						Union						
Indian River	☐						Volusia						
Jackson	☐						Wakulla						
Jefferson	☐						Walton						
Lafayette	☐						Washington						
Lake	☐												

VII. SUPPORTING DOCUMENTATION

Submit the following documentation with the completed application to substantiate the descriptions/statements:

A. INITIAL APPLICATION

1) A copy of the letter from the Florida Office of Insurance Regulation accepting the receipt of an application for a Certificate of Authority submitted by the applicant.

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

3) A copy of the articles of incorporation and all amendments thereto (i.e. name changes, mergers, and acquisitions require resubmission of these documents).

4) A statement generally describing the organization and its operations.

5) A statement describing the manner in which health care services shall be regularly available.

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

7) 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, telephone numbers, and fax numbers, as applicable.

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

9) The type of health care personnel engaged to provide the health care services and the quantity of the personnel of each type.

10) A description of the source of emergency services and care on a twenty-four hour basis.

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

12) A description of the manner in which the applicant assures the maintenance of a medical records system in accordance with accepted medical records' standards and practices.

13) Pursuant to s. 641.49(3)(o), F.S., if general anesthesia is to be administered in a facility not licensed by the agency, a copy of architectural plans that meet the requirements for institutional occupancy (NFPA 101 Life Safety Code, current edition as adopted by the State Fire Marshal)

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

15) A description demonstrating how the applicant will comply with internal risk management program requirements under s. 641.55, F.S.

16) A statement that the applicant has an established network of health care providers which is capable of providing the health care services that is to be offered by the organization. ***(Include a complete set of model contracts and first and last pages of contracts between the applicant 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/or oversight.)***

17) A statement giving the present and projected number of subscribers to be enrolled yearly for the next three years by county and product line(s) of business (i.e., Commercial, Medicaid, Medicare, Healthy Kids, etc.).

18) An explanation of how coverage for emergency services and care is provided outside of the applicant's stated geographic area.

19) An excel spreadsheet with the location of the facilities/providers 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.)***

20) A completed Provider Network Checklist, form 3160-1003, for each county being requested. Also note any access restrictions to the contracted network of providers.

21) 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.)***

B. RENEWAL APPLICATION

Submit the following documentation (may state "No Change" for numbers 1 through 7 only):

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

2) A copy of the articles of incorporation and all amendments thereto (i.e. name changes, mergers, and acquisitions require resubmission of these documents).

3) A statement generally describing the organization and its operation.

4) A statement describing the manner in which health care services shall be regularly available.

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

6) 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, telephone numbers, and fax numbers, as applicable.

7) A statement that the applicant has an established network of health care providers which is capable of providing the health care services that is to be offered by the organization. Include any executed contracts between the applicant 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/or oversight.

8) A statement giving the present and projected number of subscribers to be enrolled yearly for the next three years by county and product line(s) of business (i.e., Commercial, Medicaid, Medicare, Healthy Kids, etc.).

9) An excel spreadsheet with the location of the facilities/providers 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. ***(N/A for Florida Healthy Kids, Medicaid and Medicare.)***

10) A completed Provider Network Checklist form 3160-1003, for each county being requested. Also note any access restrictions to the contracted network of providers. ***(N/A for Florida Healthy Kids, Medicaid and Medicare.)***

11) 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. ***(N/A for Florida Healthy Kids, Medicaid and Medicare.)***

VIII. AFFIDAVIT *(These two individuals must have the authority to bind the organization.)*

We, and , hereby swear (or affirm) that we 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 our knowledge and belief.

_____ _____
Name (please print) Signature

_____
Title

_____ _____
Name (please print) Signature

_____
Title

Subscribed and sworn to before me this day of , .

_____
Notary Public

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

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