REQUEST FOR EXPANSION OF GEOGRAPHIC SERVICE AREA

Health Maintenance Organizations (HMOs), Prepaid Health Clinics (PHCs) and Exclusive Provider Organizations (EPOs)

Health Maintenance Organizations (HMOs) and Prepaid Health Clinics (PHCs) applicants **must** comply with **Subsection 641.495(3), Florida Statutes (F.S.) - Requirements for issuance and maintenance of certificate** and **Subsection 59A-12.003(4), Florida Administrative Code (F.A.C.) - Adminstration, Forms, Fees.** Exclusive Provider Organizations (EPOs) must comply with **Section 627.6472, F.S. - Exclusive provider organizations.**

Each organization shall notify the Agency for Health Care Administration (Agency) of its intent to expand its geographic service area at least 60 days prior to the date it plans to begin providing health care services in the new area. HMOs and PHCs must have the capability to provide comprehensive health care services in the requested geographical service area. Furthermore, 15 days prior to the requested expansion effective date, the HMO/PHC/EPO will demonstrate through documentation or otherwise that it will be capable of providing services to its projected subscribers for at least the first 60 days of operation.

APPLICATION INSTRUCTIONS

In order to process the expansion application in a timely manner, you must submit a **completed** expansion application and **all** of the supporting documentation as required by **Section 641.495** or **Section 627.6472, F.S.** and **Section 59A-12.003 F.A.C.** electronically. **Please do not submit paper documents.**

I APPLICATION INFORMATION

Provider Type: **(check one)**

- ☐ HMO
- ☐ PHC
- ☐ EPO

Product Line(s) of Business: **(check all that apply)**

- ☐ Commercial
- ☐ Medicare
- ☐ Medicaid
- ☐ Florida Healthy Kids

Practice Model: **(check if applicable)**

- ☐ Individual Practice Association (IPA) Model
- ☐ Staff Model
- ☐ Mixed (both IPA & Staff Model)

II ORGANIZATION IDENTIFICATION

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

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

Name		**Official Capacity**
Street Address		
City	**State**	**ZIP Code**
Telephone Number	**Fax 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	**Fax 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)

C. Identification of delegated responsibilities and oversight.

D. Quality Assurance

The organization must demonstrate or affirm the use of Agency-approved quality assurance policies and procedures that exist in approved counties will be used in expanded counties.

VI SERVICES TO BE PROVIDED IN REQUESTED SERVICE AREA

	Emergency Services and Care		Dental
	In-patient Hospital		Hearing
	Physician		Ambulance
	Ambulatory Diagnostic		Home Health
	Skilled Nursing		Pharmacy
	Rehabilitation		DME/Supplies
	Vision		Mental Health

VII CURRENT SERVICE AREA *(Check the column for each product line of business beside the current approved counties.)*

C=Commercial (HMO, PHC and EPO) **MEDICAID: ST=Standard, SPC=Specialty, LTC=Long Term Care (HMO only)**

M=Medicare (HMO only) **FHK=Florida Healthy Kids (HMO only)**

			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													

VIII **REQUESTED SERVICE AREA** *(Check the column for each product line of business beside the county being requested.)*

C=Commercial (HMO, PHC and EPO) **MEDICAID: ST=Standard, SPC=Specialty, LTC=Long Term Care (HMO only)**

M=Medicare (HMO only) **FHK=Florida Healthy Kids (HMO only)**

			MEDICAID							MEDICAID			
COUNTY	**C**	**M**	**ST**	**SPC**	**LTC**	**FHK**	**COUNTY**	**C**	**M**	**ST**	**SPC**	**LTC**	**FHK**
Alachua							**Lee**						
Baker							**Leon**						
Bay							**Levy**						
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Brevard							**Madison**						
Broward							**Manatee**						
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Indian River							**Volusia**						
Jackson							**Wakulla**						
Jefferson							**Walton**						
Lafayette							**Washington**						
Lake													

IX SUPPORTING DOCUMENTATION

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

1) A completed Provider Network Checklist for each county being requested. Also note any access restrictions to the contracted network of providers.

2) 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.

3) Complete and executed provider contracts for all providers in each requested county. Each provider contract must be a separate electronic document. Letters of Agreement must be converted to executed contracts before the expansion is approved.

4) 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.

*Only the following information is required for **Medicare, Medicaid** and **Florida Healthy Kids** expansions:*

1) Requests for Medicare expansions must include the Health Plan Management System (HPMS) View Service Area Report that shows the County, Effective Date, Status and Full/Partial County. The report cannot be accepted until the status for each requested county is listed as approved.

2) Requests for Medicaid expansions must include the executed Medicaid contract or addendum.

3) Requests for Florida Healthy Kids expansions must include approval documentation from Florida Healthy Kids for the requested counties.

X	**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 to expand the geographic service area effective DATE.

_____ _____
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 _____

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