



Oklahoma State Department of Health
Quality Assurance and Regulatory
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Oklahoma City, OK 73102
Tel. (405) 426-8175 Fax. (405) 900-7571

<u>For Oklahoma State Department of Health Use Only</u>
Date Received _____
Receipt Number _____
Project Number _____
Fee Paid \$ _____

**APPLICATION FORM FOR
WORKPLACE MEDICAL PLAN CERTIFICATION**

Type of Review: ___ New Application ___ Renewal Application ___ Other (specify below)

Specify _____

A. Name of Plan _____

Office Location _____ (_____) _____
Address City/State/Zip Code Telephone Number

B. Name and address of contact person:

Name	Mailing Address
City	State Zip Code Telephone Number (_____) _____
E-Mail Address	Fax Number (_____) _____

By my signature below, I certify this information is true and correct to the best of my knowledge and belief:

Authorized Signature for Plan	Name and Title	Date
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I. STATE OF OKLAHOMA
 COUNTY OF _____

On the ____ day of _____, 20____, before me, a Notary Public in and for the above State and County, personally appeared _____, known to me or proved to be the person named in and who executed the foregoing instrument, and being first duly sworn, such person acknowledged that he or she executed said instrument for the purposes therein contained as his or her free and voluntary act and deed.

My Commission Expires: _____

 Notary Public

(SEAL)

 Notary Number

INSTRUCTIONS

This form is composed of two parts: Part A for Initial Certification
Part B for Renewal Certification

An Applicant seeking an initial certification shall complete Part A. The applicant seeking a renewal certification shall complete the sections of Part A that have changed since the last certification application, and all sections of Part B.

An applicant seeking *Other Review* shall complete the sections of Part A that are applicable to the matter being reviewed.

Submit responses in the form of individual attachments. A list of all attachments must be included. To respond to a question, retype it, and then provide the appropriate response. Each application must be submitted in a three-ring loose-leaf binder with alphabetized tabs to identify each section.

Confidential Information

The Commissioner of Health has determined that certain sections of the application may be considered confidential information. These sections are: J, K, L, M, O, R, and T as well as secondary disclosures of these topics in other sections, such as section N. If the applicant intends this information to be considered confidential, it shall be filed as follows:

1. Submit a separate binder with this information using the appropriate section label on the tab. This binder must be labeled “**Confidential – Not Available To The Public**”. Only sections J, K, L, M, O, R, and T and secondary disclosure information can be put in this binder.
2. Submit the balance of the application in a separate binder. For sections J, K, L, M, O, R, and T include a tab with a section letter, followed by a page indicating that information can be found in the confidential binder.
3. Any material not clearly separated and labeled as confidential shall be considered public information.
4. A declaratory ruling is required for any additional sections of the application that the applicant wishes to be considered confidential. Contact the Department’s staff for further assistance.

Fee Required

A filing fee must accompany the application. The current fee for an initial or renewal application is \$1,500. There is no filing fee for an amendment to an existing application.

For more information

Contact the Managed Care Division by telephone at (405) 426-8175 or by facsimile at (405) 900-7571.

Submit application and fee to:

Oklahoma State Department of Health
Protective Health Services
Quality Assurance and Regulatory
P.O. Box 268823
Oklahoma City, OK 73126-8823

PART A – INITIAL CERTIFICATION

By separate attachments, tabbed with the item letter shown below, provide the following:

- A. A general description of the Plan and its operations, including the locations, types, and hours of providers.
- B. A copy of the Plan's basic organizational documents, such as the articles of incorporation or association, partnership or trust agreement, and all amendments.
- C. A copy of the by-laws or similar documents, regulating the Plan's conduct.
- D. A list of names, addresses, phone number, and official capacities of all persons responsible for the Plan, including:
 - 1. Each corporate officer and director, manager of a Limited Liability Company; the partners or associates of a partnership or association and of the person who will be the day-to-day Plan administrator;
 - 2. Name and address of each owner of more than five (5) percent of stock or controlling interest in the Plan, Corporation, Partnership, Association, or Limited Liability Company;
 - 3. Disclosure of any contracts or arrangements between them and the Plan, including any appearance of a conflict or interest.
- E. The medical director's name, Oklahoma license number, biographical information and address.
- F. The name, address, and biographical information of the person who will be the day-to-day Plan administrator.
- G. A description of the geographic areas to be served, including information required by OAC 310:657-9-2.
- H. A description of any facilities to be used.
- I. The categories and names of all participating providers and facilities.
- J. The written policies for credentialing health professionals and selection of providers.
- K. Projections for five (5) years, which include employee population, primary physician to employee ratios, specialty care, laboratory, x-ray and hospital services, and revenues and expenses.
- L. A financial statement for the Plan prepared in accordance with accounting principles generally accepted in the United States of America and related documents showing the Plan's financial capabilities.
- M. Forms of all provider and service contracts.
- N. Forms of all contracts with insurers and insureds showing the services to which employees are entitled.
- O. Proposed marketing or advertising materials.
- P. Description of the case management, utilization review and quality assurance process, including treatment protocols, adopted by the Plan.

- Q. A description of the Plan's or providers' medical record system.
- R. Policies for developing and reporting data.
- S. Policies for dispute resolution and grievance reviews.
- T. A plan for an employee education program.
- U. A description of the financial incentives to be used to reduce costs and control utilization.
- V. A description of the Plan's workplace health and safety consultative services for employers.
- W. The provider directory.
- X. Insurance Coverage.
 - 1. A copy of the face sheet of the errors and omissions policy. If not in effect, submit a specimen policy.
 - 2. A copy of the face sheet of the liability insurance policy. If not in effect, submit a specimen.

PART B – RENEWAL CERTIFICATION

By separate attachments, provide answers to the following:

I. Changes to the Previous Application.

- A. Has any change occurred which affect the information submitted in Part A of the previous application for certification?

_____ Yes _____ No (If “No”, skip to Section II below.)

1. If yes, resubmit the changed portions of Part A of the application.
2. List in the space below all section numbers of Part A which are affected by changes:

II. In attachments, submit data on the Plan’s experience since the last certification, including:

- A. Revenues and expenses.
- B. Changes in financial position.
- C. Employee population per month.
- D. Hospital days per injured worker.
- E. Ambulatory encounters per injured worker.
- F. Encounters by type of health professional.
- G. Disputes processed.
- H. Grievances processed.
- I. Peer review activities.
- J. Quality assurance activities.
- K. Medical record system activities.
- L. Utilization review system activities.