DEPARTMENT OF HEALTH/INSURANCE DEPARTMENT
APPLICATION COVER SHEET FOR
A CERTIFICATE OF AUTHORITY APPLICATION

All applicants for an HMO Certificate of Authority must complete this application cover sheet and include it in the front of the Certificate of Authority application.

NAME OF APPLICANT: _____

NAME UNDER WHICH THE APPLICANT PROPOSES TO MARKET ITS HMO PRODUCTS:

_____

BUSINESS ADDRESS OF APPLICANT: _____

_____

_____

PRINCIPAL CONTACT PERSON FOR HEALTH ISSUES: _____
TITLE: _____
ADDRESS (if different from above): _____

_____

_____

PRINCIPAL CONTACT PERSON FOR INSURANCE ISSUES: _____
TITLE: _____
ADDRESS (if different from above): _____

_____

TELEPHONE NUMBER: _____

FAX NUMBER: _____

PROPOSED DELIVERY SYSTEM MODEL (Briefly explain):
___ Staff Model ___ Group Practice ___ Network Model ___ Mixed Model

PROPOSED GEOGRAPHIC SERVICE AREA: _____

_____

PROPOSED METHOD OF REIMBURSING PRIMARY CARE PHYSICIANS:

___ Fee or Discounted Fee-for-Service
- ___ Without Withhold
- ___ With Withhold of ___ %
- ___ Usual, Customary and Reasonable Fee Reimbursement
- ___ Fee Schedule Reimbursement

___ Capitation

___ Other (Briefly explain):

_____

_____

IS APPLICANT A SUBSIDIARY OF, AN AFFILIATE OF, OR OTHERWISE ASSOCIATED WITH, OWNED OR CONTROLLED BY AN HMO OR AN HMO HOLDING COMPANY CURRENTLY LICENSED AND OPERATING IN ANOTHER STATE:

___ No

___ Yes

If "Yes":

NAME OF HMO: _____

STATE(S) IN WHICH LICENSED: _____

NATIONAL ASSOCIATION FOR QUALITY ASSURANCE (NCQA) ACCREDITATION STATUS OF OTHER STATE HMO AFFILIATES/PARENTS:

State	**NCQA Accreditation Status**
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Health Issues Officer **Signature of Insurance Issues Officer**