



**Commonwealth of Pennsylvania  
Insurance Department and Department of Health**

**Preferred Provider Organization (PPO) Application Form**

Application for review and approval of a PPO under the provisions of 40 P.S. §764a and 31 Pa. Code 152.1 et seq.

- I. Please identify the primary contact person for the PPO. If a different person is responsible for providing additional information/clarification concerning the filing to the Departments, that person should also be identified.

**Name:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Company Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Statutory Home Address:** \_\_\_\_\_

\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

\_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**NAIC Number:** \_\_\_\_\_

**FEIN Number:** \_\_\_\_\_

II. If the PPO will be using an independent network (rather than contracting directly with providers), please provide the following information concerning the independent network:

**Network Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**Name of Contact Person:** \_\_\_\_\_

**Title:** \_\_\_\_\_

a. Has the independent network been approved by the Department of Health?

**Yes**       **No**

b. If **Yes**, please provide date when network was approved: \_\_\_\_\_

III. PPO Type (a separate application must be submitted for each type).

a. Type:

**ERISA Exempt** (*See Exhibit I*)

**Risk Assuming Licensed Insurer**

**Non-Risk Assuming**

**Risk Assuming (Not a Licensed Insurer)**  
(*See Exhibit II*)

b. Is this a **Gatekeeper** PPO?     **Yes**       **No**

c. Is this an **Exclusive** Provider Organization (EPO)?     **Yes**       **No**

d. If this is a **Limited** type PPO, please indicate type:

**Hospital Only**

**Dental-Capitated**

**Physicians Only**

**Dental-Fee for Service**

**Vision Only**

**Mental Health/Substance Abuse**

**Other** (Describe) \_\_\_\_\_

IV. Does your PPO include provisions or arrangements which could lead to undertreatment or poor quality care, such as:

a. Provider capitation reimbursement?  **Yes**  **No**

b. Use of any type of financial incentive structure which conditions a provider's payment for service, or a portion thereof, upon gains or losses experienced by an insurer or purchaser or which allows a provider to share in such gains or losses, sometimes referred to as a fee withholding risk pool arrangement?

**Yes**  **No**

c. Is the difference in the level of coverage provided between a network provider and a non-network provider greater than 20%?

**Yes**  **No**

d. If **Yes**, please provide an explanation or justification for why the difference is greater than 20% and its impact on access to care and quality of care for the enrollee.

V. Please explain if your PPO policies, certificates or provider contracts contain any provisions or arrangements other than those listed in question IV which could lead to under-treatment or poor quality care:

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a. Please explain safeguards employed to prevent under-treatment or poor quality care:

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VI. Are all materials specified in 31 Pa. Code §152 et seq., included with this application?

**Yes**  **No**

If **No**, please list what materials have been excluded and reasons for exclusion:

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VII. If applying as a Risk Assuming PPO, are all material specified in 31. Pa. Code §89 (relating to requirements for approval of accident and health insurance policy forms) included?

Yes     No

VIII. If applying as a Gatekeeper PPO, have the requirements of the Pennsylvania Quality Health Care Accountability and Protection Act (Act 68 of 1998( (40 P.S. §991.2101, et seq.) and regulations (31 Pa. Code §054.1 et seq. and 28 Pa. Code §9.601 et seq.) regarding managed care plans been addressed?     Yes     No

If **Yes**, please identify where the information can be found in the application?

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If **No**, please list information omitted and reasons for omission.

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Does the PPO understand its ongoing responsibilities regarding the filing of additions, deletions and changes to an approved PPO (31 Pa. Code §152.3(e), (f), (g)) and annual reporting requirements (31 Pa. Code §152.19)? Note: These reports must be made with both Departments unless you are notified otherwise.

Yes     No

X. Provide any additional information/comments which might assist the Department in their review of your application.

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XI. Using the table below, please identify the counties in which you are requesting approval to operate.

Adams		Lackawanna	
Allegheny		Lancaster	
Armstrong		Lawrence	
Beaver		Lebanon	
Bedford		Lehigh	
Berks		Luzerne	
Blair		Lycoming	
Bradford		McKean	
Bucks		Mercer	
Butler		Mifflin	
Cambria		Monroe	
Cameron		Montgomery	
Carbon		Montour	
Centre		Northampton	
Chester		Northumberland	
Clarion		Perry	
Clearfield		Philadelphia	
Clinton		Pike	
Columbia		Potter	
Crawford		Schuylkill	
Cumberland		Snyder	
Dauphin		Somerset	
Delaware		Sullivan	
Elk		Susquehanna	
Erie		Tioga	
Fayette		Union	
Forest		Venango	
Franklin		Warren	
Fulton		Washington	
Greene		Wayne	
Huntingdon		Westmoreland	
Indiana		Wyoming	
Jefferson		York	
Juniata			

XII. Certification by Company Officer

*I certify that the information contained in this application, submitted for the purpose of review and approval of a preferred provider organization, is true and correct to the best of my knowledge and belief.*

\_\_\_\_\_  
(Signature of Company Officer)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Title)

- XIII. Please submit **two** (2) **signed** and **complete** copies of the application and supporting documents to **each** Department for review:

**Pennsylvania Insurance Department**

Office of Insurance Product Regulation and Administration

1311 Strawberry Square

Harrisburg, Pennsylvania 17120

Attn: **Bureau of Life, Accident and Health**

**Pennsylvania Department of Health**

Bureau of Managed Care

Room 912, Health and Welfare Building

7<sup>th</sup> and Forster Streets

Harrisburg, Pennsylvania 17120

Attn: **Division of Certification**

**CERTIFICATE OF ERISA PREEMPTION**

Pursuant to Section 630(d)(1) of the Insurance Company Law, Act of May 17, 1921, P.L. 682, as amended, and 31 Pa. Code, Section 152.12, (Name of PPO):

\_\_\_\_\_ hereby certifies that, with respect to the self-insured employee benefit plans into which its preferred-provider arrangements will be incorporated, it will function solely as a third party administrator and will assume no financial risk, and that such plans will be operating in the Commonwealth of Pennsylvania so as to be governed and regulated under the provisions of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 88 Stat.29).

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

**RISK ASSUMING PPOs**

Please contact:

**Robert E. Brackbill, Jr.** | PIR | Chief, Company Licensing Division  
Pennsylvania Insurance Department  
1345 Strawberry Square | Harrisburg, PA 17120  
Phone: 717.783.2143 | Fax: 717.787.8557  
E-mail: [rbrackbill@pa.gov](mailto:rbrackbill@pa.gov)