

QHP/SADP Data Change Request Form PY2017

Section 1

This document includes fillable form fields. If you complete electronically, please: a) Type directly in the fields below (all fields are required); b) Click on the signature field to sign electronically; c) Save the file to your desktop; d) Email the form as an attachment to:

RHLD.Compliance@arkansas.gov & Compliance@armarketplace.com.

If you write in your responses, please a) Complete the fields below (all fields are required); b) Print the form; c) Sign the form; and d) Scan the form and email to:

RHLD.Compliance@arkansas.gov & Compliance@armarketplace.com.

Issuers requesting changes to either the Plans & Benefits template or the Business Rules template must complete Supplement B electronically. More instructions on how to fill out the supplement to this data change request form can be found on the first tab of the Supplement B workbook.

Section 2

This form provides information to the Arkansas Health Insurance Marketplace regarding QHP or SADP data changes requested by:

Issuer ID: _____

Issuer Legal Name: _____

HOIS ID: _____ NAIC ID: _____

Impacted Plan IDs:

Impacted Templates and Field (if possible provide column or field reference) (Check 1):

- Administrative: _____
 - NCQA or URAC: _____
 - Essential Community Providers: _____
 - Issuer Module - Program Attestation, Licensure, Good Standing, or Network Adequacy
 - Network Adequacy (template): _____
 - Plan and Benefits Template
 - SHOP
 - Dental SHOP
- _____

- Network ID: _____
- Service Area: _____
- Prescription Drug: _____
- Benefits and Service Area Module- Supporting Documentation
- Rates Table: _____

Does this affect your Unified Rate Review Template (QHPs only)?

Yes

No

Business Rules: _____

If the Plan and Benefits Template and/or the Business Rules boxes were selected above, is a completed Supplement B attached?

Yes

No

Section 3

Description of requested QHP or SADP data changes:

If additional space is needed, please include an attachment to your request

Current Value: _____

Requested New Value: _____

Reason(s) for Requested QHP or SADP Data Changes (check all that apply):

- Issuer submitted incorrect data on QHP/SADP template(s) and must make a change to align template(s) with QHP/SADP data previously approved by AHIM.
- Issuer submitted a typographical or data entry error for which the first justification does not apply, resulting in incorrect data display on the consumer portal.
- Issuer is making routine updates to the administrative information, which includes URL changes.

Additional detail to justify need for changes:

Section 4

What is the consumer/enrollee impact of the requested changes?

How many enrollees are currently enrolled in the affected Plan IDs (and thus potentially eligible for a

notification of the change or a Special Enrollment Period to change Plans)?

What steps will you take to inform or remediate with enrollees?

Section 5

Signature:

I, _____, confirm that this QHP or SADP data change request
(Name of Authorized Representative of Issuer)
is based on true and accurate information, limited to the changes outlined above in this form,
requested for the reason(s) indicated above in this form. I confirm that
_____ (“Issuer”) will not alter or submit changes to any other QHP or
(Issuer Legal Name)
SADP data that are not submitted in this form and approved by AHIM.

I understand that it is the issuer's responsibility to ensure that the plan(s) affected by this change is in compliance with federal QHP certification standards as laid out in the Affordable Care Act, federal and state regulations, AID rules & regulations, and guidance from AHIM. AHIM recommends that issuers check their templates using the QHP Application Review Tools to ensure compliance with these standards. I understand that changes beyond what AHIM authorized, or noncompliance may be reported to AID for regulatory action.

(Signature)

(Date)

(Print Name)

(Title of Issuer Representative)

Do Not Write Below This Line -- For Office Use Only

AHIM Representative

Name: _
Title: _
Date: _

Approve

Deny

AID Representative

Name: _
Title: _
Date: _

Approve

Deny

Notes:

