Texas Department of Insurance
Health and WC Network Certification & QA, Mail Code 103-6A
333 Guadalupe • P. O. Box 149104, Austin, Texas 78714-9104
512-322-4266 telephone • 490-1013 fax • www.tdi.state.tx.us

WORKERS' COMPENSATION HEALTH CARE NETWORK APPLICATION INSTRUCTIONS

- Use letter or legal size paper
- The information must be typed. (use black ink only)
- Use white paper
- Do not highlight any areas
- Exhibits must be clearly marked with a cover sheet
- Number the pages of any documents submitted
- Submit one copy of application and exhibits
- Attach the application exhibits list to the top of your submission

I. Type of Application –Indicate what type of Workers' Compensation Health Care Network application is being filed.

- Original Application – Entity is applying for certification as a Workers' Compensation Health Care Network
    - Applicant must complete Items I – IV of the application.
    - Do not leave any spaces blank. Indicate **NA** if appropriate.
    - Completed exhibits must be the first page of your application package (See the attached exhibits list)
    - An officer or other authorized representative of the applicant must verify the application by attesting to the truth and accuracy of the information in the application.
    - Filing fee of $5000 made payable to the Texas Department of Insurance (Department) must be attached. (The fee is non-refundable)
    - **Special Instructions Regarding Attorney for Service Form:** Exhibit 1 requires the applicant to submit **Form L/FC/T/1994/SP Attserv.doc; Revised 4/2000** and the form is attached to the application. **Form L/FC/T/1994/SP** is not required if the applicant is incorporated in the State of Texas.
    - **Special Instructions Regarding Biographical Affidavits:** Exhibit 2 requires the applicant to submit a biographical affidavit for each person who governs or manages the affairs of the applicant and the form is attached to the application. A biographical affidavit is not required if a biographical affidavit from the person is already on file with the department.
- Update/change to Original Application – After issuance of a network's certification, a network shall file with the department any information that amends, supplements, or replaces the items previously filed.
    - The information must be filed as soon as practicable but not later than 30 days before implementation of any change requiring department approval, or no later than 30 days after the implementation of any change. The following must receive department approval before implementation of changes.
        - ✓ Changes to management contracts and information regarding fidelity bonds.
        - ✓ Changes to the physical location of the network's books and records.
        - ✓ Changes to the network configuration. (See Modifications to Network Configuration below).
        - ✓ Changes to existing service area. (See Modification to Service Area below).

- Applicant must complete Items I – IV of the application, as applicable (i.e. contact name has changed since issuance of certificate).
- Use the attached exhibits list to indicate what is being updated or changed.
- An officer or other authorized representative of the applicant must verify the application by attesting to the truth and accuracy of the information in the application.

➢ Modifications to Service Area – A network must file an application with and receive approval from the department before the network may expand, eliminate, or reduce an existing service area or add a new service area.
- Applicant must complete Items I – IV of the application, as applicable (i.e. contact name has changed since issuance of certificate).
- Use the Modifications to Service Area checklist to facilitate your filing.
- An officer or other authorized representative of the applicant must verify the application by attesting to the truth and accuracy of the information in the application

➢ Modifications to Network Configuration – Entity is a certified Workers' Compensation Health Care Network and is making material modifications to its network configuration.
- Applicant must complete Items I – IV of the application, as applicable (i.e. contact name has changed since issuance of certificate).
- Use the Modifications to Network Configuration checklist to facilitate your filing.
- An officer or other authorized representative of the applicant must verify the application by attesting to the truth and accuracy of the information in the application.

II. **Organization Information** – A network is not an insurer and may not use in the network's name or informational literature the word "insurance," "casualty," "surety," or "mutual" or any other word that is:
- descriptive of the insurance, casualty, or surety business; or
- deceptively similar to the name or description of an insurer or surety corporation engaging in the business of insurance in this state.

III. **Contact Information** –
- Indicate the individual who will be the primary contact for the applicant to facilitate requests from the Department regarding the application.
- Indicate the individual who will be the primary contact for detailed financial information.
- Indicate the individual who the Department will contact for complaints regarding the operations of the applicant.

IV. **Service Arrangements -** Provide information regarding entities that are performing the services or functions on behalf of the Workers' Compensation Health Care Network. If the Workers' Compensation Health Care Network is using more than one unique arrangement of contracted entities, please attach a separate table for each distinct plan of operation. (See page 3 of the application).

V. **Officer's Certification and Attestation –** An officer or other authorized representative of the applicant must verify the application by attesting to the truth and accuracy of the information in the application.

Return the application and all applicable exhibits to:

Texas Department of Insurance
Health and WC Network Certification & QA,
MC103-6A
P.O. Box 149104
Austin, Texas 78714-9104

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WORKERS' COMPENSATION HEALTH CARE NETWORK APPLICATION

I. TYPE OF APPLICATION - CHECK THE BOX THAT APPLIES

Original application ☐ & Filing Fee ($5000)
Update/Change to ☐ Original Application
Modifications to ☐ Service Area
Modifications to ☐ Network Configuration

II. ORGANIZATIONAL INFORMATION

Type of Entity:
Workers' Compensation Carrier ______
HMO ______
PPO Network ______
Provider Group ______
Utilization Review Agent ______
Other: ____________________

____
TDI Certificate Number[1]

____
Name of Workers' Compensation Health Care Network

____
Doing Business As (if applicable)

____
Mailing Address

____
City State Zip

____
Telephone Number Fax Number (Required)

____
Physical Address (if different from mailing address)

____
City State Zip

____
Telephone Number Fax Number (Required)

[1] This number is not applicable to the original application filing

Date Incorporated/Established: ____________________ Type of Organization: ___________________________
(Corporation,Partnership,LLC, etc)

City of Incorporation ____________________ State of Incorporation __________________________

Does the applicant currently hold a certificate of authority in Texas?

Yes ☐ No ☐

Company No. __________________________ NAIC No. ___________________________

Has your company ever been denied certification or licensure in this or any other state prior to the date of this application?

Yes ☐ No ☐

If Yes, give full explanation. ____

____

____

____

Are you currently licensed as a Workers' Compensation Health Care Network in another state?

Yes ☐ No ☐

If yes: State _______________ Date of Licensure ___________________ License # _________________

Please provide a listing of all other applications filed by the applicant, or any of its affiliates, which are pending before the Department.

Name	**Type**

III. CONTACT INFORMATION

Company contact for application:

Name ____

Title ____

Mailing Address ____

E-Mail Address: ___________________________Phone: _______________ Fax: ______________

Company contact for detailed financial information:

Name ____

Title____

Mailing Address ____

E-Mail Address:_________________________Phone: ______ ______ Fax: __________________

Company contact for complaints:

Name ____

Title ____

Mailing Address ____

E-Mail Address: ___________________________Phone: _______________ Fax: ______________

IV: SERVICE ARRANGEMENTS

Provide information regarding entities performing the following services or functions on behalf of the Workers' Compensation Health Care Network. If the Workers' Compensation Health Care Network is using more than one unique arrangement of contracted entities, please attach a separate table for each distinct plan of operation.

Type of Service	Name of Entity	Business Address	Contact and Telephone Number
Credentialing			
Contracting			
Quality Improvement			
Network Management			
Complaint/Dispute Resolution			

If the Workers' Compensation Health Care Network is a workers' compensation carrier, or if a free standing network plans to accept delegation of functions from carriers, please provide information regarding entities performing the function on behalf of the network.

Type of Service	Name of Entity	Business Address	Contact and Telephone Number
Utilization Review			
Payment of Medical Bills			
Bill Review			

V. Officers' Certification and Attestation

The authorized representative of the Applicant must read the following very carefully and sign below:

1. I hereby certify, under penalty of perjury, that I have read the application, that I am familiar with its contents, and that all of the information, including the attachments, submitted in this application is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license discipline or other administrative action and may subject me, the Applicant, or both, to civil or criminal penalties.
2. I acknowledge that I am familiar with the insurance and workers' compensation laws and regulations of the jurisdictions in which the Applicant is certified or to which the Applicant is applying for certification.
3. I acknowledge that I am authorized to execute and am executing this document on behalf of the Applicant.
4. Applicant acknowledges that lawful process in a legal action or proceeding against the network on a cause of action assigned in this state is valid if served in the manner provided by Texas Insurance Code Ch. 804 for a domestic company.
5. I hereby certify under penalty of perjury under the laws of the applicable jurisdictions that all of the foregoing is true and correct, executed this __________________ at ___________________.

____
Authorized Representative

____
Title

____
Date

The State of ____________

County of ____________

BEFORE ME, ____________________________________, a notary public in and for the State of_____________, on this day personally appeared ____, known to me (or proved to me on the oath of ______________________________, or through ____________________________________ to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that (s)he executed the same for the purpose and consideration therein expressed.

Given under my hand and seal of office this ______________day of _______________________20____

Affix Notary Seal Here

____
Notary Public

Applicant Name: ______________________________

WORKERS' COMPENSATION HEALTH CARE NETWORK
APPLICATION EXHIBITS

The exhibits list is intended to help guide you with assembling your complete Workers' Compensation Health Care Network application. For statutory requirements, see Texas Insurance Code Chapter 1305. For rule requirements see 28 TAC Chapter 10. Please be sure to complete the exhibits list by appropriately marking the boxes on the left side of the page prior to submitting your application for review. The completed exhibits list must the first page of your application package.

	Exhibit	Page Number	Regulator Use Only
☐	Exhibit 1 - Organizational Documents Attorney for Service Form L/FC/T/1994/SP Attserv.doc; Revised 4/2000		☐
☐	Exhibit 2 - Biographical Affidavits Officers & Directors Page Form FIN306 Rev.09/04 Biographical Affidavit Form LHL390		☐
☐	Exhibit 3 - Provider Contracts		☐
☐	Exhibit 4 - Third Party Contracts		☐
☐	Exhibit 5 – Network & Insurance Carrier Contract		☐
☐	Exhibit 6 - Management Contracts		☐
☐	Exhibit 7 - Financial Information		☐
☐	Exhibit 8 - Acknowledgement		☐
☐	Exhibit 9 - Service Area		☐
☐	Exhibit 10 - Programs & Procedures		☐
☐	Exhibit 11 – Network Configuration & Provides		☐
☐	Exhibit 12 – Physical Location of Applicants Books & Records		☐
☐	Exhibit 13 - Business Plan		☐
☐	Exhibit 14 - Financial Authorization Form Form FIN141 Rev.09/04		☐
☐	Exhibit 15 - Outside the Service Area, if applicable		☐
☐	Exhibit 16 - Maximum Medical Improvement (MMI) & Impairment Rating Services		☐
☐	Exhibit 17 – Doctor & Health Care Practitioner Financial Disclosure		☐
☐	Exhibit 18 - Notice of Network Requirements, Employee Information, Responsibilities		☐
☐	Exhibit 19 - Monitoring Plan for Providers		☐
☐	Exhibit 20 - Treatment and Return to Work Guidelines		☐
☐	Exhibit 21 – Medical Director Certification		☐