New Jersey Department of Banking and Insurance

Summary Description of Patient Appeal Process

HEALTH CARE QUALITY ACT REGISTRATION

In accordance with N.J.S.A. 26:2S-3 and N.J.A.C. 8:38A-2.2, carriers shall complete and submit an HCQA Registration form at least 30 days prior to the date that the carrier will begin to offer any health benefits plan issued under a policy or contract form for which an HCQA Registration form has not previously been filed. In addition, a carrier shall complete and submit an HCQA Registration form no later than 10 business days following the date of any substantive change to the information regarding a health benefits plan policy or contract contained in the carrier's prior HCQA Registration form filing. Business days include 8:00 AM Monday through 5:00 PM Friday, excluding any holiday recognized by the State of New Jersey through closure of its business offices.

NOTE: Affiliated companies should submit separate HCQA Registrations, completed only for their own contract forms.

NOTE: Failure to submit this form may result in fines and other penalties.

Submit by mail to:

New Jersey Department of Banking and Insurance
Valuation Bureau
PO Box 325
Trenton, NJ 08625-0325

1. CARRIER INFORMATION		
Name of Carrier		NAIC Number
Address		
Type of Carrier ☐Insurer ☐Health Service Corporation ☐Hospital Service Corporation ☐Medical Service Corporation ☐Dental Service Corporation ☐Dental Plan Organization		
2. CONTACT INFORMATION		
Name of Contact Person		Title of Contact Person
Mailing Address		
Telephone Number	Fax Number	E-mail Address

HEALTH CARE QUALITY ACT REGISTRATION
Continued

3. PRODUCT IDENTIFICATION

A. Complete the table below for all health benefits plans that incorporate utilization management features and/or are managed care plans. Attach more pages as necessary.

Form Number	Product Name and Type *(Examples of Product Type: Indemnity, SCA, PPO, HMO)*	Utilization Management[1]		Managed Care Plan[2]	
		Yes	No	Yes	No

B. Attach a copy of the certificate or handbook language describing the internal patient appeal process available to covered persons under the above-listed contract forms to contest an unfavorable utilization review decision, such as a denial, reduction or termination of benefits or services. If your company has materially different appeal processes for certain of the contract forms listed, please attach the certificate or handbook language for these separately, and indicate clearly which process applies to which contract forms. If you believe any variable text contained in the form requires explanation, please include an explanation with the form.

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[1] The term "utilization management" means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines, in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid form, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

[2] The term "managed care plan" means a health benefits plan that integrates the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan.