

**New Jersey Department of Banking and Insurance
Market Regulation
P.O. Box 329
Trenton, NJ 08625-0329**

**APPLICATION PACKAGE FOR
CERTIFICATION AS AN ORGANIZED DELIVERY SYSTEM (ODS)**

Application Checklist for ODS Certification

Please use this checklist to complete the application package. Refer to [N.J.A.C. 11:24B-2 .2, 2.3 and 2.4](#) for more detailed instructions. Applications should be mailed to: ODS Certification at the above address or delivered to: New Jersey Department of Banking and Insurance, Market Regulation, 20 West State Street, 9th Floor, Trenton, NJ 08625.

**Part A
([N.J.A.C. 11:248-2.3](#))**

- 1. A completed Application Cover Sheet and a non-refundable application fee of **\$2,500.00, payable to the Treasurer, State of New Jersey**
- 2. If the applicant organization was not organized under the laws of the State of New Jersey the Applicant must complete and execute
 - i. Irrevocable Consent to Jurisdiction of the Commissioners and New Jersey Courts
 - II. Appointment of Attorney for the State of New Jersey
- 3. A completed Financial Risk Affidavit
- 4. A copy of the ODS' basic organizational documents, as defined at [N.J.A.C. 11:24B-1.2](#)
- 5. A copy of the ODS' executed by-laws, plan of operation, rules and regulations, or similar documents intended to regulate the conduct of the ODS' internal affairs
- 6. A Biographical Affidavit completed for each of the individuals who are, or are intended to be, responsible for the conduct of the affairs of the ODS, including: i) members of the ODS' board of directors, executive committee or other governing board or committee; ii) the ODS' principal officers, and medical director, if applicable; iii) any person who owns or has the right to acquire 10 percent or more of the voting securities of the ODS; iv) each person that has loaned funds to the ODS for the operation of the ODS' business; and v) partners or members, in the case of a partnership or association ([NAIC Form 11](#))
- 7. A business plan consisting of:
 - i. an organizational chart of the ODS;
 - ii. a narrative description of the ODS, its facilities, and personnel, and the health care services to be offered by the ODS to a carrier;
 - iii. a list of the geographical areas in which the described health care services are to be performed and approximate number of each type of provider who will provide the health care services;
 - iv. a description of any administrative services for which the ODS shall be responsible on behalf of the carrier;
 - v. a list of any affiliate of the ODS that provides services to the ODS in New Jersey and a description of any material transaction between the affiliate and the ODS;

- vi. a description of any arrangements between the ODS and any other ODS or subcontractor for services associated with the provisions of health care services;
 - vii. a description of any reinsurance or stoploss arrangements;
 - viii. a plan, in the event of insolvency of the ODS, for continuation of the health care services to be provided in accordance with existing contracts and laws;
 - ix. a description of the means by which the ODS will be compensated under contracts with carriers;
 - x. a description of the arrangement for the ODS reporting of data to the carriers and a description of the carrier's oversight responsibility.
- 8. A specimen copy of all provider agreements made or intended to be executed between the ODS and providers
 - 9. A specimen copy of all contracts made or intended to be executed between the ODS and any other ODS or subcontractor for services associated with the provision of health care services
 - 10. A specimen copy of all management agreements made or to be executed between the ODS and one or more carriers
 - 11. A list of all administrative, civil or criminal actions and proceedings to which the ODS, its affiliates, or persons who are responsible for the conduct of the affairs of the ODS or affiliate, have been subject, including a statement regarding the resolution of such actions and proceedings.
 - 12. A list of the carriers with which the ODS has contracted or intends to execute a contract pending the approval of the application
 - 13. A list of all states in which the ODS has been or currently is doing business as described in the application

Part B
(N.J.A.C. 11:248-2.4)

- 1. Services for which certification is being sought (please check all that apply):
 - 1. ___ Performance of one or more types of health care services delivery
 - 2. ___ Network management
 - 3. ___ Credentialing and recredentialing
 - 4. ___ Utilization management development
 - 5. ___ Utilization management application
 - 6. ___ Utilization management appeals
 - 7. ___ Member complaints
 - 8. ___ Provider complaints
 - 9. ___ Continuous quality improvement ("CQI")
- 2. For performance of one or more types of health care services delivery:
 - a. List of names of all providers by county, municipality, zip code, and services
 - b. Map of the service area identifying the location of the participating providers
 - c. Criteria to assure the availability and accessibility of services to be performed

- 3. For network management:
 - a. Demonstration of adequacy of the network for services offered in relation to population to be served consistent with standards at N.J.A.C. 11:24B-3.5
 - b. Demonstration of the CQI program
 - c. Demonstration of the complaint and appeal system for providers
 - d. Demonstration of the provider participation panel
 - e. Demonstration of the hearing panel for provider terminations
 - f. Demonstration of records maintenance procedures and standards
 - g. Credentialing and recredentialing standards

- 4. For credentialing and recredentialing:
 - a. Policies and procedures demonstrating compliance with N.J.A.C. 11:24B-3.6
 - b. Designated medical director and his/her functions
 - c. Explanation of linkage and coordination with the CQI and complaint systems of the carrier(s) and/or their other contractor(s), including flow chart(s)

- 5. For utilization management development:
 - a. Policies and procedures for developing protocols and guidelines, demonstrating compliance with N.J.A.C. 11:24B-3.7
 - b. Designated medical director and his/her functions
 - c. Copy of the protocols and guidelines developed, and instructions for use

- 6. For performance of utilization management:
 - a. Policies and procedures, demonstrating compliance with N.J.A.C. 11:24B-3.8
 - b. Designated medical director and his/her functions
 - c. Explanation of medical director's oversight, if employed by the carrier
 - d. Explanation of the UM criteria used

- 7. For utilization management appeals:
 - a. Policies and procedures, demonstrating compliance with N.J.A.C. 11:24B-3.9
 - b. Designated medical director and his/her functions
 - c. Flow chart demonstrating communication and decision-making, if the medical director is employed by the carrier
 - d. Specimens of letters regarding appeal rights and decisions on appeals to be sent to both covered persons and providers.

- 8. For member complaints:
 - a. Policies and procedures, demonstrating compliance with N.J.A.C. 11:24B-3.12
 - b. Explanation of linkage and coordination with the CQI and complaint system of the carrier(s) and/or their other contractor(s)
 - c. Explanation of how complaints are segregated among carriers (and other clients)
 - d. Specimens of the letters regarding complaint and complaint resolution to be sent to covered persons and providers acting on behalf of covered persons

- 9. For provider complaints:

- a. Policies and procedures, demonstrating compliance with N.J.A.C. 11:24B-3.11
 - b. Explanation of linkage and coordination with the CQI and complaint system of the carrier(s) and/or their other contractor(s)
 - c. Explanation of how complaints are segregated among carriers (and other clients)
 - d. Specimens of the letters regarding a complaint and complaint resolution to be sent to providers
10. For continuous quality improvement:
- a. Policies and procedures, demonstrating compliance with N.J.A.C. 11:24B-3.10
 - b. Explanation of linkage and coordination with the complaint systems and other continuous quality improvement components that the carrier(s) may have
 - c. Designated medical director and his/her functions

Part C
(N.J.A.C. 11:24B-2.2)

- 1. Application in 3-ring binder(s), labeled with the ODS' name, and serially numbered, if necessary
- 2. Application tabbed, exhibits segregated, and shown in order requested in regulations
- 3. All pages numbered
- 4. All specimen contracts contain unique identifier in lower left corner of each page
- 5. Payment by check or money order made payable to the "Treasurer, State of New Jersey"
- 6. No items left blank

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**APPLICATION PACKAGE FOR
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APPLICATION COVER SHEET**

1. Type of Application: Certification	2. Name of Applicant
3. Physical Address of Applicant: _____ _____ _____	4. Mailing Address: _____ _____ _____
5. Organizational Information <input type="checkbox"/> Corporation <input type="checkbox"/> Trust <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Professional Association <input type="checkbox"/> Other	
6. Provide a brief description of the services that the applicant will be providing:	
7. City and State of Incorporation (if applicable) City: _____ State: _____	
8. Federal Employer Identification Number _____ or Social Security Number _____	
9. Contact Person Information: Name: _____ Title: _____ Telephone Number: _____ Toll-Free Number: _____ Fax Number: _____ E-mail Address: _____	
10. Resident Status - Resident of New Jersey? <input type="checkbox"/> Yes <input type="checkbox"/> No	County in which Home Office is located for NJ Residents
Certification I, (<i>Name and Title</i>): _____ certify that I am authorized to file this certification on behalf of the applicant, the information set forth in the enclosed application and herein is true to the best of my information, knowledge and belief, and that the Department of Banking and Insurance may rely on the information set forth in the application and herein in determining whether to grant a license or certificate pursuant to <u>N.J.S.A. 17:48H-1 et seq.</u> I further certify that the applicant is familiar and will comply with the requirements set forth in <u>N.J.S.A. 17:48H-1 et seq.</u> and rules promulgated pursuant thereto.	
Full Legal Name of Applicant (Type or Print)	Title
Signature of Applicant	Date

Appointment of Attorney for the State of New Jersey

KNOW ALL MEN BY THESE PRESENTS: That the _____
of the _____ of _____
in the _____ of _____,
desiring to do business in the State of New Jersey in conformity with the laws thereof, hereby,
constitutes and appoints the Commissioner of Banking and Insurance of New Jersey, and his or her
successor in office, to be its true and lawful Attorney, upon whom all original process in any action
or legal proceeding against said _____
may be served. And the said _____
hereby stipulates and agrees that any original process against it, which is served upon said Attorney,
shall be of the same legal force and validity as if served upon said _____,
and that the authority of said Attorney shall continue in force irrevocable so long as any liability of said
_____ remains outstanding in New Jersey.

IN WITNESS WHEREOF, the said _____
has caused these presents to be subscribed by its President, and attested by its Secretary, and its
corporate seal to be hereunto affixed, this _____ day of _____,
20____.

(Corporate Seal-if applicable)

Attest:

*Signature of President
(or authorized representative)*

(Print or Type Name)

*Signature of Secretary
(or authorized representative)*

(Print or Type Name)

FINANCIAL RISK AFFIDAVIT

(Print or Type)

I, _____, _____,
(Name of Officer) *(Title)*

an officer of _____ being duly authorized to
(Name of ODS)

provide this affidavit on behalf of _____, do
(Name of ODS)

hereby attest and affirm that _____, does not
(Name of ODS)

engage in the acceptance of the transfer of financial risk from any carrier as defined by N.J.S.A. 17:48H-1 et. seq., and rules promulgated pursuant thereto and shall not accept a transfer of financial risk from any carrier until such time as _____

(Name of ODS)

becomes licensed by the New Jersey Department of Banking and Insurance. Further, I attest and affirm that the compensation arrangement(s) set forth in this application do not constitute the transfer of financial risk.

Dated and signed this _____ day of _____, 20_____ at

_____. I hereby certify under penalty of perjury that I am acting on my own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

(Signature of Affiant)

State of _____

County of _____

Personally appeared before me the above named _____
(Name of Officer of ODS)

personally known to me, who, being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____ day of _____, 20 ____ .

(Notary Public)

My Commission Expires _____