ARKANSAS All-PAYER CLAIMS DATABASE (APCD) ANNUAL REGISTRATION FORM

Pharmacy Benefit Manager (PBM) and Third-Party Administrator (TPA)

INTRODUCTION

Act 1233 of 2015 of the Arkansas 90th General Assembly, also known as the "Arkansas Healthcare Transparency Initiative Act of 2015" (hereafter "Transparency Initiative"), requires a "submitting entity" to submit data to the Transparency Initiative. Arkansas Insurance Department (AID) Rule 100 further defines "submitting entity." Submitting entities subject to Rule 100 are required to register annually between January 1 and March 31. The Arkansas APCD Data Submission Guide establishes the data submission schedule for submitting entities.

For the purpose of determining whether an entity meets the threshold of 2,000 covered individuals and is therefore subject to data submission requirements, an entity must aggregate covered individuals for medical, dental, and pharmaceutical plans for all companies affiliated with the entity's NAIC group code. Excluded from the aggregate are individuals covered by vision plans and accident-only, specified disease, hospital indemnity, long-term care, disability income, or other supplemental benefit coverage from which benefit payments are directly paid to the covered individual. For aggregation purposes, entities may count individuals covered by two or more plans only once.

Exemptions to the requirements in Act 1233 of 2015 and Rule 100 will be contingent on the completion of this registration form. If you have questions regarding this form, please call (501) 526-4306 or email: **support@achiapcd.atlassian.net**

Please email completed forms to **support@achiapcd.atlassian.net** entering "Registration" in the subject field or deliver to:

Arkansas Center for Health Improvement
1401 West Capitol Avenue
Suite 300, Victory Building
Little Rock, Arkansas 72201

ENTITY INFORMATION

1. Entity Name		
2. State of Domicile		
3. Mailing Address		
4. City	**5. State**	**6. ZIP Code**
7. Compliance/Government Relations Contact Person		
8. Contact Phone Number	**9. Contact Email**	

10. List employee benefit plans for which you act as third party administrator.

(Types of plans inlcude self-funded and fully insured. Use an additional page if needed.)

Name of Employer	Federal Tax ID #	Type of Plan	# of Covered Individuals

ATTESTATION

This section must be signed by an officer authorized to legally bind the entity named in Box 1 on page 1 if the entity determines it is NOT a "submitting entity" as defined by Act 1233 of 2015 and AID Rule 100. Do not complete this section if the entity qualifies as a "submitting entity."

_____ (Name), being a duly authorized representative, hereby attest that _____ (Group Name) is not a "submitting entity" as defined by Act 1233 of 2015 and Rule 100. I understand and acknowledge that the Arkansas Insurance Department may review the validity of this attestation.

12. Please provide a justification for attestation:

Signature

Typed or Printed Name

Date

REGISTRATION

A Group that attests it is not a "submitting entity" is not required to complete this section.

Entity Name		
Mailing Address		
City	**State**	**ZIP Code**

Line of Business

☐ Comprehensive Major Medical ☐ Fraternal ☐ Third Party Administrator

☐ Pharmacy Benefits Manager (PBM) ☐ Dental ☐ Government

☐ Other

File Type

☐ Medical Claims ☐ Pharmacy Claims ☐ Provider

☐ Dental Claims ☐ Enrollment

*Identify the **technical support staff** who will work with the Arkansas Center for Health Improvement regarding data submission. The primary contact listed below will be designated to receive a username and password required for data submission once the process is in place.*

Primary Contact Person (Last Name, First Name)	**Job Title**
Contact Phone Number	**Contact Email**
Secondary Contact Person (Last Name, First Name)	**Job Title**
Contact Phone Number	**Contact Email**

If a vendor will be submitting data, provide the vendor information below.

Vendor Name (Last Name, First Name)	**Contact Person**
Contact Phone Number	**Contact Email**