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

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: **arapcd@uams.edu**

Please email completed forms to **arapcd@uams.edu** 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. NAIC Group Code	**2. Group Name**	
3. State of Domicile		
4. Mailing Address		
5. City	**6. State**	**7. ZIP Code**
8. Compliance/Government Relations Contact Person		
9. Contact Phone Number	**10. Contact Email**	
11. Number of Individuals Covered by the Group *(see the explanation provided in the Introduction section to determine which individuals to include in this calculation)*		

ATTESTATION

This section must be signed by an officer authorized to legally bind the entity named in Box 1 (NAIC Group Code) 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.

Identify the company(ies) affiliated with the NAIC Group and provide the corresponding information. Do not include companies that exclusively provide a health insurance or benefit plan that is accident-only, specified disease, hospital indemnity, long-term care, disability income, or other supplemental benefit coverage from which benefit payments are directly to the covered individual.

NAIC Company Code (1)	**Company Name**	
Mailing Address		
City	**State**	**ZIP Code**

Line of Business (*select all that apply to this NAIC Company Code*)

☐ Comprehensive Major Medical ☐ Fraternal ☐ Third Party Administrator

☐ Pharmacy Benefits Manager (PBM) ☐ Dental ☐ Government

☐ Other

File Type (*select all that apply to this NAIC Company Code*)

☐ Medical Claims ☐ Pharmacy Claims ☐ Provider

☐ Dental Claims ☐ Enrollment

Does the company contract with a PBM to process pharmacy claims? ☐ Yes ☐ No

Number of Covered Individuals as of December 31:

*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**

REGISTRATION

Identify the company(ies) affiliated with the NAIC Group and provide the corresponding information. Do not include companies that exclusively provide a health insurance or benefit plan that is accident-only, specified disease, hospital indemnity, long-term care, disability income, or other supplemental benefit coverage from which benefit payments are directly to the covered individual.

NAIC Company Code (2)	**Company Name**	
Mailing Address		
City	**State**	**ZIP Code**

Line of Business (*select all that apply to this NAIC Company Code*)

☐ Comprehensive Major Medical ☐ Fraternal ☐ Third Party Administrator

☐ Pharmacy Benefits Manager (PBM) ☐ Dental ☐ Government

☐ Other

File Type (*select all that apply to this NAIC Company Code*)

☐ Medical Claims ☐ Pharmacy Claims ☐ Provider

☐ Dental Claims ☐ Enrollment

Does the company contract with a PBM to process pharmacy claims? ☐ Yes ☐ No

Number of Covered Individuals as of December 31:

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

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NAIC Company Code (3)	**Company Name**	
Mailing Address		
City	**State**	**ZIP Code**

Line of Business (*select all that apply to this NAIC Company Code*)

☐ Comprehensive Major Medical ☐ Fraternal ☐ Third Party Administrator

☐ Pharmacy Benefits Manager (PBM) ☐ Dental ☐ Government

☐ Other

File Type (*select all that apply to this NAIC Company Code*)

☐ Medical Claims ☐ Pharmacy Claims ☐ Provider

☐ Dental Claims ☐ Enrollment

Does the company contract with a PBM to process pharmacy claims? ☐ Yes ☐ No

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

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

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NAIC Company Code (4)	**Company Name**	
Mailing Address		
City	**State**	**ZIP Code**

Line of Business (*select all that apply to this NAIC Company Code*)

☐ Comprehensive Major Medical ☐ Fraternal ☐ Third Party Administrator

☐ Pharmacy Benefits Manager (PBM) ☐ Dental ☐ Government

☐ Other

File Type (*select all that apply to this NAIC Company Code*)

☐ Medical Claims ☐ Pharmacy Claims ☐ Provider

☐ Dental Claims ☐ Enrollment

Does the company contract with a PBM to process pharmacy claims? ☐ Yes ☐ No

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