



# STATE OF CONNECTICUT

## INSURANCE DEPARTMENT

### Preferred Provider Network (PPN) License Instructions and Application (Renewal)

Connecticut General Statutes § 38a-479aa requires all Preferred Provider Networks (PPNs) offering services in the State of Connecticut to be licensed by the Connecticut Insurance Department (“Department”). If you have any questions about your responsibility to be licensed, please refer to Conn. Gen. Stat. §38a-479aa and any applicable amendments. The Connecticut General Statutes can be accessed at <http://www.cga.ct.gov/asp/menu/Statutes.asp>

#### Instructions:

- To assure that a PPN license be confirmed without interruption in Connecticut, the Department needs applications to be submitted two months in advance. Connecticut law requires that license renewal applications be submitted by March 1st of each year. If your network meets the guidelines for licensure, an invoice for the license fee of \$2750 will be forwarded to you. This invoice must be paid prior to the license effective date.
- The application must be filled out, completed, and signed by the CEO of the PPN entity certifying that all information provided is true and accurate.
- Submit your application and attachments to:

State of Connecticut Insurance Department  
Fraud, Licensee Investigations and Compliance Unit  
P O Box 816  
Hartford, CT 06142-0816

#### Hand delivery or Overnight delivery address ONLY:

153 Market Street, 7th floor  
Hartford, CT 06103

**DO NOT SUBMIT THE LICENSE FEE WITH THIS APPLICATION. You will be billed.**

Once licensed, the law requires the PPN to submit quarterly and annual financial reports. To comply, please refer to Conn. Gen. Stat. §38a-479aa and forward those reports to the Department at the address above.



**Preferred Provider Network (PPN)  
License Application (Renewal)**

Name of PPN: \_\_\_\_\_

PPN CT License Number: \_\_\_\_\_

PPN Tax Identification Number (TIN/FEIN) \_\_\_\_\_

PPN Business Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PPN Mailing Address (if different): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PPN Phone Number: \_\_\_\_\_

Does your PPN provide services for workers' compensation only?     NO         YES

**If YES**, you are *not required* to complete this application. Please return this page and the signed CEO Certification (page 7) to the Insurance Department at the address on the Instructions page.

Is your organization registered with the Department as a Pharmacy Benefit Manager ("PBM") pursuant to Conn. Gen. Stat. Secs. 38a-479aaa et seq.?     NO     YES

**If YES**, you are *not required* to complete this application. Please return this page and the signed CEO Certification (page 7) to the Insurance Department at the address on the Instructions page.

Has any suspension, sanction or disciplinary action been taken against the PPN in Connecticut or any other state?

No

Yes    If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Has any suspension, sanction or disciplinary action been taken against the controlling company or organization in Connecticut or any other state?**

No

Yes If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe the PPN's service area:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**How many total enrollees are served by the PPN: Nationwide: \_\_\_\_\_ in CT: \_\_\_\_\_**

**List participating hospitals in Connecticut:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List all entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees (e.g. Managed Care Organizations):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Indicate the type(s) of reimbursement arrangements that the PPN enters into with entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees (e.g. Managed Care Organizations/MCO):**

Capitation

Fee for Service

Other -- Please explain: \_\_\_\_\_

\_\_\_\_\_

Indicate types of services that the PPN provides for entities on whose behalf the PPN has contracts or agreements to provide health care services to Connecticut enrollees (e.g. Managed Care Organizations):

- Medical services
- Utilization Review – if checked, your CT License Number: \_\_\_\_\_
- Claims administration
- Dental Services
- Other – List types of services

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Indicate type(s) of reimbursement arrangements that the PPN enters into with participating providers:

- Capitation
- Fee for Service
- Other -- Please explain: \_\_\_\_\_

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**PLEASE SUBMIT THE FOLLOWING AS ATTACHMENTS:**

- A list of participating primary care physicians, the specialty physicians and other providers, including the number and percentage of each group’s capacity to accept new patients.
- A description of the general criteria for selection and/or termination of providers.
- A list of subcontractors of the PPN that provide health care services to Connecticut enrollees and assume financial risk from the PPN; and to what extent each assumes risk. This does not include individual participating providers.
- A table of all major categories of health care services provided by the PPN.
- contingency plan describing how contracted health care services will be provided in the event of insolvency.
- \* Proof that the PPN meets minimum security standards as defined in Conn. Gen. Stat. Sec. 38a-479aa(i) as amended by Public Act 07-191.

Proof can be in the form of a letter of credit, bond, surety, reinsurance, or reserve exclusively held for “...use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment...”. [Sample bond language is attached.]

Please note that the beneficiary of the financial security instrument are the members/providers. Under no circumstance should the State of Connecticut or the State of Connecticut Insurance Department be named as the beneficiary.

- [ ] The most recently concluded fiscal year-end financial statements for the PPN AND
- [ ] The most recently concluded fiscal year-end financial statements for the controlling company or organization.

- If the last fiscal year-end financial statements (for the PPN and the controlling company or organization) ended more than 90 days prior to your license application date, you must also include an internally prepared financial statement (using GAAP) for the quarter ending within the 90 days prior to that date. The next fiscal year-end financials must be sent to the Department within 120 days of your fiscal year-end.
- Financial statements must be “Reviewed” or “Audited” by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP).
- Any other material change since last year.

\* **Financial Security Requirement:**

*Pursuant to the relevant part of Conn. Gen. Stat. Sec.38a-479aa as amended by Public Act 07-191, the financial security amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for two months determined on the basis of the two months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner.*

Enter below the months, the year, and the amounts in which the network’s total payments to provider/members were the highest within the past year. In addition, please provide the amount currently owed to provider/members. As stated above, the instrument used to meet the financial security requirement will be based on the greater of two highest months or the current outstanding amount due.

Highest months of payments to providers within the past year:

**Sum of two highest months:**  
(Connecticut business Only)

\$ \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_  
\$ \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_

\$ \_\_\_\_\_

Actual outstanding amount due providers \$ \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



**SAMPLE BOND FORM**

**STATE OF CONNECTICUT  
PREFERRED PROVIDER NETWORK (PPN) BOND**

**KNOW ALL MEN BY THESE PRESENTS**

That we, \_\_\_\_\_ of the  
(Name of PPN)  
County of \_\_\_\_\_ State of \_\_\_\_\_  
as Principal, and \_\_\_\_\_, a surety  
company having its principal place of business in \_\_\_\_\_  
County of \_\_\_\_\_ State of \_\_\_\_\_ duly authorized to  
do business in the State of Connecticut, as Surety, are held and firmly bound unto the  
member/providers of the Preferred Provider Network (PPN) named, as Obligees, in the sum of  
\_\_\_\_\_ dollars (\$\_\_\_\_\_) for the  
payment of which sum the said Principal and Surety do jointly and severally bind themselves, their  
heirs, executors, administrators, successors, and assigns, and each and every one of them firmly by  
these presents.

**THE CONDITION OF THIS OBLIGATION IS SUCH THAT WHEREAS,** the  
Principal has made application to the Insurance Commissioner of the State of Connecticut for a  
license to engage in the business of a Preferred Provider Network (PPN) in accordance with the  
provisions of Section 38a-479aa of the Connecticut General Statutes and any applicable  
amendments and any regulation promulgated thereunder. This surety is intended for the sole  
purpose of meeting the obligation as described in Section 38a-479aa(i) "...for the exclusive use of  
paying any outstanding amounts owed participating providers in the event of insolvency or  
nonpayment except that any remaining security may be used for the purpose of reimbursing  
managed care organizations in accordance with subsection (b) of section 2 of this act."

**PROVIDED HOWEVER,** that all obligations upon this bond shall cease upon the  
voluntary or involuntary termination of such license except as to such liability as shall have been  
accrued thereto.

**IN WITNESS WHEREOF,** the said Principal and Surety have signed and sealed this  
instrument this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

**WITNESS**

\_\_\_\_\_  
(As to Principal) By \_\_\_\_\_ L.S.  
\_\_\_\_\_  
\_\_\_\_\_  
(As to Surety) By \_\_\_\_\_ L.S. Corporate Seal  
\_\_\_\_\_  
\_\_\_\_\_ L.S.