ATTACHMENT A

Insure Oklahoma ESI Insurance Plan Application

(For Insurance Carriers Only)

Insure Oklahoma

I. CONTACT INFORMATION	
Carrier Name	
Health Plan Name	
NAIC Number (5-digit)	
Contact Name	
Address	
City	
State	
Zip Code	
E-Mail	
Main Telephone number	
Direct Telephone number	
Fax	
Alternate contact	

II. Identified Requirements	Yes	/ No	Explanation
1. Does the plan cover hospital services?			
2. Does the plan cover physician services?			
3. Does the plan offer office visits?			
4. Is the office visit co-payment $50 or less?			
5. Does the plan cover lab & radiology?			
6. Does the plan offer pharmacy benefits (if offered as a rider, is the rider optional or mandatory)?			
7. Is the pharmacy deductible $500.00 or less per calendar year?			
8. Is the pharmacy co-pay $50.00 or less?			
9. Is the total individual annual out-of-pocket maximum (including deductibles and co-insurance) less than or equal to $3,000?			
10. What is the total deductible for individual and family?			

For OHCA Use Only

III. Did the carrier supply all of the required documents as requested?

Required Documents	Yes	/ No	Explanation
1. Application			
2. Statement of Benefits			
3. Covered Benefits			
4. Description of Premium Calculation			
5. EOB, Premium Rate Sheet, and Sample Invoice			

IV. Recommendation	Reasons for Denial (If any)

V. Committee Decision	Reasons for Denial (If any)
APPROVAL DISAPPROVAL Date:	