Ohio High Risk Pool
Third Party Payer Application

Background

Before any organization can pay for coverage issued to an enrollee in Ohio's high risk pool program, the organization must be certified by the Ohio Department of Insurance. To be considered for certification as a third party payer, an organization must complete the application in its entirety, and must certify to the statements in the "certification" section. The Ohio high risk pool will not accept payment from a third party payer unless and until it has been certified by the Ohio Department of Insurance. Enrollees must pay for their own coverage unless and until payment is made by a third party payer that has received the approval of the Ohio Department of Insurance.

Instructions

Applicants must provide complete responses to all questions. In addition, an individual with authority to bind the organization must attest to the statements in the certification section by providing a notarized signature. Applicants may attach additional information.

Completed applications can be emailed to the Ohio Department of Insurance at PayerCertification@insurance.ohio.gov, or forwarded to the following address:

Ohio Department of Insurance
Attn: Legal Division
50 W. Town Street
Columbus, OH 43215

Contact Information

Please provide the following information:

Name of Organization _____

Address _____

Primary Contact

Name _____

Title _____

Phone Number _____

Email _____

Website _____

(Continue on the following page...)

Details about the Applicant

Please respond to the following questions on a separate page that should be included with your application.

1. Is the organization a governmental or non-profit organization?
2. What is the organization's governmental or charitable purpose?
3. Does the organization have members? If so, identify or describe the members?
4. How is the organization funded? Is funding received from health insurance companies or health care providers? Identify or describe the funding sources or funders.
5. Does the organization provide health insurance benefits? If so, describe the benefits and identify or describe who receives such benefits?
6. Does the organization provide financial assistance to individuals? If so, describe the types of financial assistance provided and identify or describe who receives such assistance?
7. Identify or describe the people whose high risk pool premiums will be paid for by the organization? Are there eligibility criteria with respect to such individuals and, if so, what are the criteria? How are individuals selected?
8. Will financial assistance for high risk pool coverage be provided to employees or others working for or on behalf of the organization?
9. Will the organization, its funders or members, financially benefit directly or indirectly from high risk pool coverage? If so, describe the financial benefits that would be received.

Certifications

I hereby certify that the following statements are true and accurate with respect to the applicant:

10. The applicant is a governmental or non-profit charitable organization.
11. The applicant is not an insurance carrier or third party administrator.
12. The applicant is not a hospital or health care provider that would make payments on behalf of any high risk pool enrollee who would be a patient of the hospital or health care provider.
13. The applicant will not financially benefit, directly or indirectly, from amounts paid by the high risk pool program on behalf of enrollees.
14. The applicant will not pay for high risk pool coverage on behalf of employees or their dependents.
15. All answers and statements on this application are true and complete.

(Continue on the following page...)

I hereby attest, as if under oath, that I have fully and truthfully completed this form to the best of my knowledge, information and belief. I further avow that I am in a position to know the information that has been provided. I further avow that I have the authority and legal capacity to execute this certification on behalf of the Applicant.

Organization Name: _____

By: _____
(Signature)

_____
(Printed Name)

_____
(Title)

Date: _____

Acknowledgment of Individual

STATE OF OHIO COUNTY OF _____
The foregoing instrument was acknowledged before me this _____ day of _____,
_____ by _____.

_____

Notary Public

My Commission Expires _____.