Data Submitter Annual Registration Form
State of Connecticut All Payer Claims Database (APCD)

Under Connecticut law, each Reporting Entity must register with the APCD Administrator annually[1]. Per the APCD Policies and Procedures, data related to the following types of policies shall be excluded from the files submitted by Reporting Entities: hospital confinement indemnity coverage; disability income protection coverage; accident only coverage; long term care coverage; specified accident coverage; Medicare supplement coverage; specified disease coverage; TriCare Supplemental Coverage; travel health coverage; and single service ancillary coverage, with the exception of dental and prescription drug coverage. Reporting entities that have fewer than a total of 3,000 Members enrolled in plans not otherwise excluded from the files that are offered or administered by the Reporting Entity on October 1 of any year, and are exempt from the data submission requirements set forth in APCD's Policy and Procedure for the following calendar year, except that all Reporting Entities shall comply with Annual Registration Requirements.

The registration form shall indicate whether the Reporting Entity is processing claims for Members and, if applicable, the types of coverage, current enrollment in each coverage type, and claims volume in calendar year 2013.

If a respondent has questions about this registration requests or this form, please contact the Access Health Analytics help desk at Ctapcd.Analytics@ct.gov.

Completed forms can be sent electronically or by mail:

Mail:	**Email:**
Administrator, All-Payer Claims Database, Access Health CT (AHCT) *280 Trumbull St., 15th Floor* *Hartford, CT 06103*	Ctapcd.Analytics@ct.gov

[1] Please see appendix for Public Act 13-247, Section 144 definition of "Reporting Entity"

1. Reporting Entity Information

Submitter Entity Name: _____

Type of Business:
☐ Health Plan
☐ Third Party Administrator
☐ Dental Health Plan
☐ Pharmacy Benefits Manager
☐ Government Agency

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

2. Compliance Contact Information

Contact First Name: _____ Contact Last Name: _____

Title: _____ Email Address:_____

Company Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

3. Please complete the section below with figures for 1 month of data from the population you plan to submit (Please provide figures for the month of October if possible):

Coverage Type	Medical Coverage	Pharmacy Coverage
Number of Comprehensive Medical Commercial Coverage Members		
Number Medicare Part C Covered Members		
Number Medicare Part D Covered Members		

4. Does the submitter provide coverage (Comprehensive medical with carve outs, pharmacy, or dental) to over 3,000 members as of October 1, 2013 (Definition of a member can be found on page in the CT APCD Policies and Procedures)?

☐ Yes

☐ No

5. If your plan carves out services (e.g., pharmacy, vision, dental, mental health) please indicate those services and carve-out organizations in which data will not be sent?

_____

_____

_____

_____

6. Please complete the contact information below for the eligibility data you plan to submit:

Contact First Name: _____ Contact Last Name: _____

Title: _____ Email Address:_____

Company Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

7. Please complete the contact information below if you plan to submit medical claims data:

5a. Estimated number of claims submitted per month _____

5b. Estimated number of paid dollars per month _____

Medical contact information is the same contact as:

☐ Eligibility

Contact First Name: _____ Contact Last Name: _____

Title: _____ Email Address:_____

Company Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

8. Please complete the contact information below if you plan to submit pharmacy claims data:

6a. Estimated number of claims submitted per month _____

6b. Estimated number of paid dollars per month _____

Pharmacy contact information is the same contact as

☐Eligibility ☐ Medical

Contact First Name: _____ Contact Last Name: _____

Title: _____ Email Address:_____

Company Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

9. Please complete the contact information below if you plan to submit dental claims data:

6a. Estimated number of claims submitted per month _____

6b. Estimated number of paid dollars per month _____

Dental contact information is the same contact as

☐Eligibility ☐ Medical ☐ Pharmacy

Contact First Name: _____ Contact Last Name: _____

Title: _____ Email Address:_____

Company Name: _____

Phone: _____ Fax: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

10. Additional Comments:

_____

_____

_____

_____

Appendix

Public Act 13-247, Section 144 – Definition of APCD Reporting Entity:

(2) (A) "Reporting entity" means:

(i) An insurer, as described in section 38a-1 of the general statutes, licensed to do health insurance business in this state;

(ii) A health care center, as defined in section 38a-175 of the general statutes;

(iii) An insurer or health care center that provides coverage under Part C or Part D of Title XVIII of the Social Security Act, as amended from time to time, to residents of this state;

(iv) A third-party administrator, as defined in section 38a-720 of the general statutes;

(v) A pharmacy benefits manager, as defined in section 38a-479aaa of the general statutes;

(vi) A hospital service corporation, as defined in section 38a-199 of the general statutes;

(vii) A nonprofit medical service corporation, as defined in section

38a-214 of the general statutes;

(viii) A fraternal benefit society, as described in section 38a-595 of the general statutes, that transacts health insurance business in this state;

(ix) A dental plan organization, as defined in section 38a-577 of the general statutes;

(x) A preferred provider network, as defined in section 38a-479aa of the general statutes; and

(xi) Any other person that administers health care claims and payments pursuant to a contract or agreement or is required by statute to administer such claims and payments.

(B) "Reporting entity" does not include an employee welfare benefit plan, as defined in the federal Employee Retirement Income Security Act of 1974, as amended from time to time, that is also a trust established pursuant to collective bargaining subject to the federal Labor Management Relations Act.