FORM CR2

Bermuda Health Council BHeC

Application to Require Payment of the Insured Portion

This form is for use by health service providers who wish to apply for permission to require payment by an insured person of the insured portion of a procedure in accordance with section 5 of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012.

You may refer to the explanatory notes overleaf

PART A – HEALTH SERVICE PROVIDER (PRACTICE) INFORMATION

Name of health service provider [Note 1]:

Category of health service provider (if the business operates several services indicate all relevant categories e.g. a physician office that operates a practice and lab) [Note 2]:

☐ Allied health – specify: _____ ☐ Complementary /alternative – specify: _____

☐ Dental practice ☐ Lab ☐ Optometry practice ☐ Pharmacy ☐ Physician practice ☐ Psychology practice

☐ Other – Specify: _____

Street address [Note 3]:	Parish:	Postal Code:
Mailing address: ☐ Tick if same as street address [Note 3]		
Office Manager or Health service provider [Note 4]:		☐ Mr ☐ Ms
Email (Office Manager) [Note 5]:	Phone No.:	Fax:

PART B – INSURER INFORMATION AND EVIDENCE

Name of offending insurance company [Note 6]:

To document that 5% of submitted clean electronic claims (e-claims) over the preceding three months are not paid by the insurer within 30 days. State figures and provide evidence of the total number of [Note 7]:

1. e-claims submitted to all insurers
2. e-claims submitted to offending insurer
3. clean e-claims submitted to offending insurer
4. clean e-claims not paid within 30 days (delayed payment) by offending insurer

Forms of evidence can include:

1. Computer generated report(s) indicating the details of above and/or
2. Receipt of evidence, including electronic acknowledgement letters, email trails, and facsimile (showing the date and time of submissions).

PART C – DECLARATION OF THE APPLICANT

NOTE: This form must be completed by Office Manager or the health service provider and indicate he/she has read and accepted the following declaration [Note 8].

☐ I _____, hereby certify that the information contained in this application is true and correct in all material aspects. I acknowledge that any of the information provided in this form may be copied, recorded, or used by the Bermuda Health Council for the purpose of ensuring compliance under section 5 of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012. I will notify the Bermuda Health Council of any change in circumstances that may impact this application.

Date: _____

PART D – INTERNAL USE ONLY

Date received: dd / mmm / yy Reference No.:

Has application been made for insurer under section 10 of Act ? ☐ Yes ☐ No Was permission granted? ☐ Yes ☐ No

☐ Approved ☐ Approval time period: _____ to _____

☐ Conditions:

☐ Declined Reasons: _____

Sterling House, 3rd Floor, 16 Wesley Street, Hamilton HM11, Bermuda | PO Box HM 3381, Hamilton HM PX, Bermuda
Phone: 441-292-6420 | Fax: 441-292-8067 | bdahealthcouncil@bhec.bm | www.bhec.bm

FORM CR2

Application to Require Payment of the Insured Portion

This form is for use by health service providers who wish to apply for permission to require payment by an insured person of the insured portion of a procedure in accordance with section 5 of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012.

Explanatory Notes

Under section 5(1) a health service provider may apply to the Council for permission to require payment by an insured person of the insured portion of a procedure.

Under section 5(3) when making an application under subparagraph (1), the health service provider must provide—

a) evidence that, with respect to at least five percent of claims submitted to the insurer over a period of three months—
   i. the insurer has failed to pay clean claims by the time prescribed under paragraph 9(1); or
   ii. the insurer has failed to pay clean claims by the time directed by the Council pursuant to paragraph 10(3)(a); and

b) any documentation or answer any questions which the Council may consider relevant to the application.

Under section 5(4) the Council may also require the insurer to provide any documentation or to answer any questions which it may consider relevant, including whether the insurer intends to apply to the Council under paragraph 10(1) to vary the time requirement.

The Regulations are on www.bermudalaws.bm. Supporting information is available on the Bermuda Health Council's BHeC's website: www.bhec.bm under Health Insurance and Forms.

Instructions for completing this form:

This form can be completed electronically or manually. However, the **form must be submitted by email**. All parts of the form must be completed.

PART A: Application Details

1. **Name of health service provider:** The name inserted should be the official name of the provider/facility
2. **Category of health service provider:** If the business operates several services indicate all relevant categories e.g. a physician office that operates a practice and lab
3. **Addresses:** Both the street and mailing addresses of health service provider must be provided
4. **Office Manager or Health service provider:** Name of person with designated responsibility for management of the practice who is to be the initial point of contact in regard to this application
5. **Email address:** of the Office Manager

PART B: Insurer Information and Evidence

6. Provide the name of the insurance company that failed to pay five percent (5%) of clean electronic claims (e-claims) within 30 days in the past three months
7. Provide figures and detailed clear and convincing evidence that at least 5% of clean e-claims submitted to the offending insurer over a period of three months indicate that the insurer has failed to pay clean e-claims by the time:
   - prescribed under paragraph 9(1); or
   - directed by the Council pursuant to paragraph 10(3)(a);

PART C: Declaration of the Applicant

8. The Office Manager must read and accept the declaration and certify that the information contained in this application to require payment by an insured portion of a procedure is true and correct in all material aspects.

Submitting this form:

The completed form and the relevant documents should be submitted to Bermuda Health Council:

a. by email to healthcouncil@bhec.bm
b. include the term **"Require payment of insured portion"** in the subject line

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