ARKANSAS HEALTH INSURANCE MARKETPLACE
1 Commerce Way, 502
Little Rock, AR 72202

QHP/SADP Data Change Request Form

Section 1

This document includes fillable form fields. If you complete electronically, please: a) Type directly in the fields below (all fields are required); b) Click on the signature field to sign electronically; c) Save the file to your desktop; d) Email the form as an attachment to:
Tanya.Barton@arkansas.gov & Chantel.Allbritton@arkansas.gov.

If you write in your responses, please a) Complete the fields below (all fields are required); b) Print the form; c) Sign the form; and d) Scan the form and to emails above.

Issuers requesting changes to either the Plans & Benefits template or the Business Rules template must complete Supplement B electronically. More instructions on how to fill out the supplement to this data change request form can be found on the first tab of the Supplement B workbook.

Section 2

This form provides information to the Arkansas Health Insurance Marketplace regarding QHP or SADP data changes requested by:

Issuer ID:_____
Issuer Legal Name: _____

☐ HOIS ID: _____ ☐ NAIC ID: _____

Impacted Plan IDs:

_____
_____

Impacted Templates and Field (if possible provide column or field reference) (Check 1):

- ☐ Administrative: _____
- ☐ NCQA or URAC: _____
- ☐ Essential Community Providers: _____
- ☐ Issuer Module - Program Attestation, Licensure, Good Standing, or Network Adequacy
- ☐ Network Adequacy (template): _____
- ☐ Plan and Benefits Template
  - ☐ SHOP
  - ☐ Dental SHOP

_____
_____

- ☐ Network ID: _____
- ☐ Service Area: _____
- ☐ Prescription Drug: _____
- ☐ Benefits and Service Area Module- Supporting Documentation
- ☐ Rates Table: _____

Does this affect your Unified Rate Review Template (QHPs only)?

- ☐ Yes
- ☐ No

☐ Business Rules:_____

If the Plan and Benefits Template, Service Area and/or the Business Rules boxes were selected above, is a completed Supplement B attached?

- ☐ Yes
- ☐ No

Section 3

Description of requested QHP or SADP data changes:

If additional space is needed, please include an attachment to your request

Current Value: _____

Requested New Value: _____

Reason(s) for Requested QHP or SADP Data Changes (check all that apply):

- ☐ Issuer submitted incorrect data on QHP/SADP template(s) and must make a change to align template(s) with QHP/SADP data previously approved by AHIM.
- ☐ Issuer submitted a typographical or data entry error for which the first justification does not apply, resulting in incorrect data display on the consumer portal.
- ☐ Issuer is making routine updates to the administrative information, which includes URL changes.

Additional detail to justify need for changes:

Section 4

What is the consumer/enrollee impact of the requested changes?

How many enrollees are currently enrolled in the affected Plan IDs (and thus potentially eligible for a notification of the change or a Special Enrollment Period to change Plans)?

_____
_____
_____
_____
_____

What steps will you take to inform or remediate with enrollees?

_____
_____
_____
_____
_____

Section 5

Signature:

I,_____, confirm that this QHP or SADP data change request
(Name of Authorized Representative of Issuer)
is based on true and accurate information, limited to the changes outlined above in this form, requested for the reason(s) indicated above in this form. I confirm that
_____ ("Issuer") will not alter or submit changes to any other QHP or
(Issuer Legal Name)
SADP data that are not submitted in this form and approved by AHIM.

I understand that it is the issuer's responsibility to ensure that the plan(s) affected by this change is in compliance with federal QHP certification standards as laid out in the Affordable Care Act, federal and state regulations, AID rules & regulations, and guidance from AHIM. AHIM recommends that issuers check their templates using the QHP Application Review Tools to ensure compliance with these standards and include the screenshot in SERFF. I understand that changes beyond what AHIM authorized, or noncompliance may result in regulatory action.

(Signature)	(Date)
(Print Name)	(Title of Issuer Representative)

Do Not Write Below This Line -- For Office Use Only

AHIM/RHLD Representative

Name:
Title:
Date:

☐ Approve ☐ Deny

Notes: