COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
DIVISION OF HEALTH INSURANCE POLICY AND MANAGED CARE

RISK-SHARING ARRANGEMENT INFORMATION SHEET

THIS FORM MUST BE SUBMITTED TO THE KENTUCKY DEPARTMENT OF INSURANCE WITH A COPY OF YOUR RISK-SHARING ARRANGEMENT AGREEMENT. YOU MUST ALSO SUBMIT COMPLETED FORM HIPMC-F1.

1. Indicate the number of enrollees affected by the risk-sharing arrangement: _____

2. Indicate the health care services to be provided to an enrollee under the risk-sharing arrangement:

   _____

   _____

3. Indicate the nature of the financial risk to be shared between the insurer and entity or provider, including, but not limited to, the method of compensation:_____

   _____

   _____

4. Indicate any administrative functions delegated by the insurer to the entity or provider. Attach a plan to demonstrate that the entity or provider is complying with KRS 304.17A-500 to 304.17A-590 in exercising any delegated administrative functions:_____

   _____

   _____

5. Attach the insurer's oversight and compliance plan regarding the standards and method of review used by the insurer: _____

   _____

Authorization of individual completing this form.

_____ _____ _____
NAME (Manual Signature Required) POSITION DATE

_____
NAME (Print or Type)