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QHP/QDP Application Data Change Request Form

Issuers are required to complete this form for data change requests to be processed during Data Change Correction Windows. This form must be accompanied with the State Authorization Form with Section 1 completed by the issuer, and a formal letter explaining potential impact to consumers in regards to the change request.
Issuers can submit this form via email to **pmanagement@exchange.nv.gov.**

This attachment provides information to the Silver State Health Insurance Exchange (SSHIX) regarding QHP or QDP data changes requested by:

Issuer ID: _____

State: _____

Issuer Legal Name: _____

Impacted Plan ID(s):

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

☐ Issuer Module - Program Attestation, Licensure, Good Standing, or Network Adequacy/Essential Community Providers
☐ Issuer Module Supporting Documents- Organization Chart, Compliance Plan, Licensure/Good Standing documents, ECP/NA justifications, QIS
☐ Network Adequacy/Essential Community Providers (template): _____
☐ Plans and Benefits Template*
- Individual
- SHOP
- Dental Individual
- Dental SHOP

Does this affect your Actuarial Value (AV) calculation?
- Yes (if yes, the issuer needs to submit the plan's old and new AV Calculator screenshots, along with a copy of the old and new version of the Plans and Benefits Template)
- No

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

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

☐ Yes

☐ No

☐ Business Rules*:_____

Description of requested QHP or QDP data changes:

*If additional space is needed, please include an attachment to your request Templates marked with a * require Supplement B in addition to this worksheet provided by CMS.*

Current Value: _____

Requested New Value: _____

_____

_____

_____

Reason for Requested QHP or QDP Data Changes:

☐ Issuer submitted incorrect data on QHP/QDP template(s) and must make a change to align template(s) with QHP/QDP data previously approved by SSHIX or the Division of Insurance (DOI)

☐ Issuer submitted a typographical (i.e., data entry) error for which the first justification does not apply, resulting in incorrect data display on the Exchange consumer portal. Evidence must be attached.

Additional detail to justify need for change(s):

_____

_____

_____

State Approval Documentation

Issuer must complete Section 1 of the QHP/QDP State Authorization form.

Signature:

I,_____, confirm that this QHP or QDP 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, and has been approved by the applicable state, as appropriate. I confirm that state evidence of approval will be included with this request and that _____ ("Issuer") will not alter or submit changes to any other QHP
(Issuer Legal Name)
or QDP data that are not submitted in this form and approved by SSHIX.

I understand that it is the issuer's responsibility to ensure that the plan(s) affected by this change is in compliance with federal and state QHP/QDP certification standards as laid out in the Affordable Care Act, federal and state regulations. SSHIX recommends that issuers check their templates using the QHP Application Review Tools to ensure compliance with these standards. I understand that SSHIX will be reviewing the resubmission of the Issuer's QHP or QDP data, and changes beyond what SSHIX authorized or noncompliance may result in the suppression of the Issuer's QHP or QDP.

_____ _____

(Signature) (Date)

_____ _____

(Print Name) (Title of Issuer Representative)