State of California
Health and Human Services Agency
Department of Managed Health Care
PRE-FILING REQUEST FORM
DMHC 10-195 Rev: 08/22

Pre-Filing Request Form

To assist the Department of Managed Health Care's Office of Plan Licensing in scheduling a pre-filing conference, please complete the form by entering information into the applicable fields and checking the applicable boxes. Submit completed forms to Duty.Counsel@DMHC.CA.GOV and allow 5 business days to process. Please direct questions on the status of requests to (916) 324-9046.

Dated: _____

- (●) Non-Licensed Entity
- ( ) Licensed Health Care Service Plan

Brief Description *(Describe the purpose of the requested pre-filing below)*

SECTION I – PRIMARY PRE-FILING POINT OF CONTACT
1. Contact Name *(Last, First)*
2. Title *(i.e. Director, President, CEO, Counsel, etc.)*
3. Phone Number
4. Email Address

SECTION II – PLAN/ENTITY INFORMATION	
5. Legal Name of Entity	Plan ID Number *(If applicable)* 933-XXXX
6. DBA or Fictitious Name of Entity	
7. Primary Business Address *(Applicants only)*	
8. Primary Mailing Address *(Applicants only)*	

SECTION III – PROPOSAL DETAILS

9. Proposed Filing:

- ☐ Initial Application
- ☐ New Product Offering
- ☐ Service Area Expansion/Withdrawal
- ☐ Other *(Describe below)*

10. Proposed License Restriction:

- ○ Unrestricted
- ◉ Restricted

11. Proposal to Contract with:

- ☐ CMS
- ☐ DHCS
- ☐ Covered CA
- ☐ Other

12. Proposed Service(s):

- ☐ **N/A**
- ☐ Acupuncture
- ☐ Behavioral
- ☐ Chiropractic
- ☐ Dental
- ☐ EAP
- ☐ Full-Service
- ☐ MA Only
- ☐ Pharmacy
- ☐ Vision

13. Proposed Market(s): ☐ **N/A**

☐ Commercial - Individual ☐ Commercial - Small ☐ Commercial - Large

☐ Medicare, MAPD, or SNP ☐ Medi-Cal ☐ Cal MediConnect

☐ Other *(Describe below)*

14. Proposed Product Type(s)[1]: ☐ **N/A**

☐ HMO ☐ PPO ☐ EPO

☐ POS ☐ HSP ☐ OTHER *(Describe)*

15. Are you proposing to contract with a KKA Health Plan?:

◉ No ○ Yes *(List below)*

16. If you are currently an unlicensed entity, what KKA Health Plan(s) or Risk Bearing Organization(s) are you affiliated with (if any)?

17. Anticipated Date for Approval of Filing: ☐ **N/A**

18. Anticipated Filing Date:

19. Provide Entity's Availability *(3-5 dates with two hour blocks, 2-3 weeks out)*:

[1] Acronyms: **CMS** – U.S. Centers for Medicare and Medicaid Services; **DHCS** – California Department of Health Care Services; **Covered CA** – Covered California; **MA** – Medicare Advantage; **HMO** – Health Maintenance Organization; **PPO** – Preferred Provider Organization; **EPO** – Exclusive Provider Organization; **POS** – Point of Service; **HSP** – Healthcare Service Plan; **KKA** – Knox Keene Act