Online Compliance Application Instructions

The Health Care Stabilization Fund's online compliance application has been designed to make entering data easier. This reference guide provides basic instructions and examples for completing the form. For more detailed instructions, download a copy of the "Notice of Basic Coverage Instructions" found on the forms page of the HCSF website. HCSF Forms and Supporting Documents | Kansas Health Care Stabilization Fund

Upon submittal of each entry, a confirmation page will be shown for that entry with further options and information. Remember that submittal of the online application does not conclude the compliance process. The submitted form will be reviewed by HCSF staff to determine accuracy and completeness. In addition, the correct premium surcharge must be received.

If entering a valid Kansas license number, please ensure that it is entered exactly as listed on file with the Kansas Board of Healing Arts (BOHA), including a hyphen if that is how the license is listed with BOHA. (e.g.; 04-12345)

Those few health care providers who are not licensed by the State (for example, professional corporations and limited liability companies) may enter their federal employer identification number in the license number field.

Fund Compliance E-Form Data Entry by Section

Section 1 – Provider General Information

This section establishes whether this form is for an individual or for a business entity or group. Please note that the last name field doubles as a Business Name field if the entry is for a business. First and Middle name are NOT required if the entry is for a business.

Name	Description/Instruction	Required?
KS License Number	Enter Kansas Med License # (include hyphen if applicable) No license? Enter EIN #.	Yes
Provider Type	Select whether Individual or Business Entity.	Yes
Profession	Depending on the choice in made for the "Provider Type", please select the specific category for the provider from the appropriate drop down menu.	Yes
Last Name or Business Name	If the provider is an individual, enter their last name. If business, enter business name.	Yes
Provider First Name	If the provider is an individual, please enter their first name.	For Individuals
Provider Initial	If the provider is an individual, enter middle name or initial.	No
Provider Suffix	If the provider is an individual, enter applicable suffix (Sr., Jr., III, etc.).	No
Provider Phone	Telephone Number for Provider	Yes
Provider Email	Provider Email Address	No

Section 2 – Provider Addresses

This section captures the provider's home residence address AND the business address where the provider performs their services. Both addresses are required.

Name	Description/Instruction	Required?
Street (Residence)	Residence Street Number and Street Name	Yes
City	Residence City	Yes
State	Residence State	Yes
Zip Code	Residence Zip Code	Yes
Zip Code Extension	Residence Zip Code 4 digit Extension	No
Business Name	Business Name (for Addressing Mail)	No
Business Address	Business Street Address	No
Business City	Business City	No
Business State	Business State	No
Business Zip Code	Business Zip Code	No
Business Zip Ext.	Business Zip Code Extension	No

Section 3 – Provider Insurance Coverage Information

This section is for providing information related to the private insurance policy and coverage centric to the entered provider.

Name	Description/Instruction	Required?
Insurance Company Name	Enter the name of the Insurance Company providing private insurance for this provider. If the company is not found in the drop-down menu, please select "Other" and enter name of company in the next field.	Yes
Insurance Other	If "Other" is elected in the previous field, please enter the Insurance Company Name in this field.	*
Insurance Address	Street Address of the Insurance Company providing private Insurance coverage.	Yes
Insurance City	Insurance Company City	Yes
Insurance State	Insurance Company State	Yes
Insurance Zip	Insurance Company Zip Code	Yes
Insurance Zip Ext	Insurance Company Zip Code Extension	No
Policy Number	Private Insurance Policy Number	Yes
Effective Date	Effective Date of the Private Insurance Policy	Yes
Expiration Date	Expiration Date of the Private Insurance Policy	Yes
Policy Type	Select "C" for a claims made policy or "O" for Occurrence.	Yes
Coverage Limits/Aggregate	Enter the coverage limits per claim and the annual aggregate separated with /. (ex: 500,000/1,500,000)	Yes
Annual Premium	Enter the cost of the private policy annual premium.	Yes
Policy Features	Are there any unique stipulations or features with this policy?	No

Section 4 – HCSF Categorization and Surcharge Information

This section determines the Health Care Stabilization Fund required Coverage Level and Surcharges. For instructions regarding calculation of the correct HCSF premium surcharge, refer to the instructions for the Notice of Basic Coverage or the Non-Resident Certification, which may be downloaded from the forms page. HCSF Forms and Supporting Documents | Kansas Health Care Stabilization Fund

Name	Description/Instruction	Required?
HCSF Group Number	Please enter the group number (if unknown, this can be found in the documents listed in the paragraph above.)	Yes
Has MO License	Does the provider also have a Missouri Medical License?	Yes
Compliance Year	How many years has the provider been in HCSF compliance 1, 2, 3 or greater. If more than 3 years, please enter 3.	Yes
Pro Rata Year Percentage	If the policy is for only part of the year, indicate the percentage of the year (ex: 50% = 6 months) Leave blank for full year.	No
Premium Surcharge	Enter the Premium Surcharge Due.	Yes
KS Practice Allocation	This field is for non-residents only - ratio (percent) of practice allocated in Kansas. Enter the percentage of time working in KS. (ex: 50% = 6 months)	No
Calculate Surcharge	For both residents and non-residents - calculated HCSF Premium Surcharge (minimum $200)	Yes

Section 5 – Certification and Acknowledgement

This section is to Certify and Acknowledge the entries made within this form. For Insurers of Kansas residents, please select “Certify Info” and fill out the Insurance Representative’s name and contact information. For those who are not legal residents of Kansas, but have a license to practice in Kansas, select the second option “Certify Knowledge.”

Name	Description/Instruction	Required?
Certify Info	For residents of Kansas – select this option.	*
Insurance Rep Name	If the previous field was selected, please fill out the Insurance Rep Name.	*
Insurance Rep Phone	If the Certify Info field was selected, please enter the Insurance Rep Phone Number.	*
Insurance Rep Email	If the Certify Info field was selected, please enter the Insurance Rep Email.	*
Certify Knowledge	For non-Residents of Kansas who have a license to practice in Kansas, please select this option.	*
Method of Payment	Please select either Pay online or mail check. If mailing a check, please BE SURE to enclose a list of providers covered by the mailed payment.	Yes

If the option to pay online has been selected, the user can click the link to the KANPAY payment portal where they will be able to pay for up to 10 providers per batch. If the user has more than 10 providers to enter/pay, they must make multiple payments through this portal for each batch of 10.

If paying with a check by mail, the data entry person must print out the payment sheet which is to be included with the mailed check. This payment sheet must contain the names of the providers for which the payment is being made. Failure to include this sheet will potentially cause delays in payment processing.