SCC Use Only	

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE
ARBITRATOR CHANGE REQUEST/ TERMINATION FORM

Please submit this completed form to BBVA@scc.virginia.gov to update information or terminate your participation as an Arbitrator in Virginia's process.

Section 38.2-3445.02 of the Code of Virginia directs the State Corporation Commission (SCC) to develop a list of approved arbitrators for use by parties pursuing arbitration of out-of-network balance billing disputes.

Please identify whether this application is a request for:

☐ An update to previously submitted information.
Complete: Name, Arbitrator ID, Contact Information, Information to be updated, and Sign the Attestation. Other than these specified items, there is no need to provide any additional information.

☐ A request to be removed from the list of available Arbitrators at: scc.virginia.gov.
Complete: Name, Arbitrator ID, Contact Information, and Sign the Request to Terminate. Other than these specified items, there is no need to provide any additional information.

Arbitrator Name: _____
(☐Check here if changed and provide previous name) _____

Firm Name, if applicable: _____
(☐Check here if changed and provide previous name) _____

Arbitrator ID (assigned at approval): _____
Contact us at BBVA@scc.virginia.gov if you do not know your Arbitrator ID.

Contact Information to which an Arbitration Request should be sent (electronic delivery will be used in most cases):

Address: _____ *(☐Check here if changed)*
City: _____ State: _____ Zip: _____
Phone: _____ *(☐Check here if changed)*
Fax: _____ *(☐Check here if changed)*
Email: _____ *(☐Check here if changed)*

Please list the fee(s) to be charged for arbitration through this process. The fee(s) stated below must be the final amount, inclusive of indirect costs, administrative fees, and incidental expenses.

Fee for individual claim: _____ *(☐Check here if changed)*
Fee for bundled claims: _____ *(☐Check here if changed)*
Address for payment: _____ *(☐Check here if changed)*
City: _____ State: _____ Zip: _____

Arbitration/Dispute Resolution Experience
(Provide any updates to the below information)

Arbitration certification/other professional license, including year admitted/year license issued:

Report any professional license not in good standing:

Membership in associations related to healthcare, arbitration or dispute resolution:

Completion of any professional arbitration association courses (course name, description and date completed):

Legal practice/health professional positions:

Indicate number of years' experience, percentage of dedication to any of the following activities, and, if the following were conducted for health carriers, please provide the name(s):

- Health care billing disputes:
- Carrier and provider/facility contract negotiations:
- Health services coverage disputes:
- Coding expertise or experience (also explain the expertise or experience):
- Practicing attorney:
- Arbitration experience:
- Other applicable experience (include any specific areas of arbitration expertise not identified above):

List your most recent training related to healthcare or dispute resolutions by the American Arbitration Association, the American Health Lawyers Association or a similar entity:

Indicate the name of any training you completed for arbitrator applicants made available by the SCC:
Note: There may be a period when the training has not been developed.

Conflict of Interest
(Provide any updates to the below information)

Do you represent insurance carriers: ☐ Yes, I do ☐ Yes, my firm does ☐ No
If yes to either, identify the carrier(s) and designate the percentage of yours/your firm's practice dedicated to this activity:

Do you represent providers or facilities: ☐ Yes, I do ☐ Yes, my firm does ☐ No
If yes to either, identify the provider(s) or facility(ies) and designate the percentage of yours/your firm's practice dedicated to this activity:

Please indicate any (i) current or recent ownership of, or partial ownership of; (ii) material professional, familial, or financial conflict of interest; or (iii) employment with, any health carrier, or health care professional, health care facility or other health care provider:

If applicant performs external reviews for health carriers or independent external reviews, please indicate the type of reviews performed and any contracts with health carriers to perform the reviews:

Attestation
(Complete for a Change Request)

Attestation (to be signed by the individual):

I, _____, do hereby certify that I will adhere to the rules of the arbitration process, and arbitrator reporting requirements and deadlines established pursuant to § 38.2-3445.02 of the Code of Virginia and applicable Rules Governing Balance Billing for Out-of-Network Health Care Services. I agree that neither I nor my firm will use information gained through this arbitration process for any other purpose. I will arbitrate all matters coming before me faithfully and with fairness to all parties and perform all associated duties with due diligence and good faith. I will disclose information, including any potential conflicts of interest, to the parties and the Commission as required by applicable rules. My signature acknowledges that the information provided in this application is true and correct, and that I have read and understand the requirements of § 38.2-3445.02 of the Code of Virginia, and I agree to be bound by it, along with applicable rules.

Signed_____

Date_____

Request to Terminate
(Complete for a Request to Terminate)

I, _____, no longer wish to provide arbitration services for the arbitration process established pursuant to § 38.2-3445.02 of the Code of Virginia and the Rules Governing Balance Billing for Out-of-Network Health Care Services (14VAC5-405-10 et seq.). Therefore, I am providing my request to the State Corporation Commission Bureau of Insurance to remove my name from the list of available arbitrators. Should I wish to provide arbitration services in the future for this process, I understand that I must again apply for approval. My signature acknowledges that the information provided in this application is true and correct.

Signed_____

Date_____