

STATE OF NEW JERSEY
Department of Banking and Insurance
Designated Hemophilia Health Care Provider
2025 Annual Report

Name of Provider

December 31, 2025
Year Ending

Please submit the report electronically to the addresses below:

Barbara Hanlon
Supervising Healthcare Evaluator
New Jersey Department of Banking and Insurance
Office of Managed Care
PO Box 329
20 West State Street, 9th Floor
Trenton, New Jersey 08625-0329

E-mail: Barbara.Hanlon@dob.nj.gov and
Danielle.Cifelli@dob.nj.gov

Thank you for your cooperation.

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Hemophilia Health Care Provider

ADMINISTRATIVE INFORMATION

Date of Designation: _____

Main Administrative Office: _____
(Street)

(City, State & Zip Code)

Contact Person: _____
(Name) (Area Code & Telephone Number)

(E-Mail)

CERTIFICATION BY OFFICER

As Chief Executive Officer of _____, I certify that all information and statements made in this Annual Report are true, complete, and current to the best of my knowledge and belief.

Name of Chief Executive Officer

Signature

CHANGES IN OPERATIONS

Pursuant to N.J.A.C. 11:24C-2.12, the designated provider shall report changes in writing at least 30 days prior to the expected date of change, or within no more than 10 days following the date of a change that was unexpected. Identify any change in operations not reported to the Department during 2025, or from the date of approval as a Designated Hemophilia Health Care Provider.

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1. Complete the chart below to identify each carrier under contract during 2025 and to report the number of covered persons, per carrier, who received services during the calendar year.

| Carrier | Number of Patients Served |
|---------|---------------------------|
| | |
| | |
| | |
| | |

2. Submit a current organizational chart, identifying the names and titles of the persons responsible for operations. Include the principal officers and medical director, if applicable
3. Provide proof of all required licenses/certifications needed to conduct business in the State of New Jersey, including waste disposal contracts. (Blood Bank, Pharmacy license, etc.)
4. Provide proof of inventory available that will also verify access to all products, assays and contractual agreements with pertinent manufactures and/or distributors.
5. Provide a copy of all patient intake, evaluation and follow-up policies and procedures, including initial information on fee/reimbursements structure and emergency delivery procedures.
6. Provide a copy of all insurance reimbursement, billing and assistance procedures.
7. Explain how nursing services are provided on an as needed basis.
8. Explain the process for tracking and monitoring the timely delivery of services to all covered persons.

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9. Provide a copy of all performance reports submitted to each carrier.
10. During the past year, has the agency been required to submit a Plan of Correction (POC) to a carrier? If yes, provide a copy of the POC (s) and confirm the POC was accepted by the carrier.
YES _____ NO _____
11. During the past year, has the agency, or any of its affiliates, failed to meet a carrier's performance measure(s) or been penalized by a carrier? If yes, provide a list of the performance measure(s) and/or penalties.
YES _____ NO _____
12. During the past year, has the agency, its affiliates, or persons who are responsible for the conduct of the agency or affiliates been subject to any administrative, civil or criminal actions and proceedings. If yes, provide a list of the actions and a statement regarding the resolution of such actions.
YES _____ NO _____
13. Report the total number of complaints received during the past year. Identify the top three (3) categories of complaints:

| CARRIER | Number of Complaints | Complaint Categories |
|---------|----------------------|----------------------|
| | | |
| | | |
| | | |
| | | |

14. Is complaint data reported to carriers? YES _____ NO _____
If yes, include a copy of the data reported to the carrier(s).

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15. Complete the chart below to report the number of covered persons treated by type of bleeding disorders.

| <u>Client Census by Bleeding Disorder as of December 31, 2025</u> | | | | |
|---|--------------|--------------|------------------------|---------------------------|
| | Hemophilia A | Hemophilia B | von Willebrand Disease | Other Factor Deficiencies |
| Report number of fully insured covered persons | | | | |