Read instructions before completing form

FIS 0320 (11/24) Department of Insurance and Financial Services

HMO Inpatient Discharges & Benefit Payouts Report

File with your quarterly and annual statements. Provide data based on calendar year.

Filing is required for: All HMOs	2025
	DUE quarterly

Name of HMO

NAIC Group number and Co. code

Indicate which report you are filing.

- ☐ 2024 Annual data DUE March 1, 2025
- ☐ Q1 data DUE May 15, 2025
- ☐ Q2 YTD DUE August 15, 2025
- ☐ Q3 YTD DUE November 15, 2025

Section 1-Contracted Hospitals *Attach additional sheet(s) if necessary*

Name of contracted hospital	Total number of Inpatient Discharges		
	Elective	Emergency	Total
Subtotals:			

Address questions about this form to Office of Insurance Evaluation 517-284-8762

continued on page 2

Section 2-NON-Contracted Hospitals *Attach additional sheets if necessary*

Name of NON-Contracted hospital	Total number of Inpatient Discharges		
	Elective	Emergency	Total
Subtotals:			

Section 3-Discharge Statistics

	Elective Inpatient Discharges from Contracted Hospitals	Elective Inpatient Discharges from NON-Contracted Hospitals	TOTAL Elective Inpatient Discharges from Contracted AND NON-Contracted Hospitals
Number of Discharges			
Percentage of Discharges	%	%	100%
Enter amount (in dollars) of 3 month projected incurred claims from non-contract hospitals			$

Section 4- Total Benefit Payouts

	Total Benefit Payout	Percentage of Payments
Total payments to contracted providers	$	%
Total payments under Hospital Access Agreement (Medicaid only)	$	%
Total payments to non-contracted providers	$	%
Total medical and hospital expenses paid	$	100%

Section 5- Interrogatories

1. Does the HMO have medical malpractice or managed care errors and omissions coverage? ☐ Yes ☐ No *If yes, please complete below:*

Name of carrier	Limits of coverage	Expiration date

Certification

I certify that I am an officer of the HMO named in this report, and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature	Date signed	Person and phone number to contact regarding this report
Signer's name and title typed or printed		

PA218 of 1956 as amended requires submission of this form by all licensed Health Maintenance Organizations. Failure to complete and submit this form properly could result in a compliance action or revocation of your authority to do business in Michigan.