CHAPTER 10. LIFE, ACCIDENT AND HEALTH

SUBCHAPTER 1. GENERAL PROVISIONS

PART 1. GENERAL PROVISIONS

365:10-1-18. Annual provider directory audit report

(a) **Reports of inaccurate information.** Each health benefit plan, as defined in 36 O.S. § 6060.4, shall offer the general public a clearly identifiable and easily accessible way in accordance with 36 O.S. § 6971 to report inaccurate information in the plan's provider directory. No later than two (2) days after receipt of a report of inaccurate information, the plan shall investigate and either verify or update the information.

(b) **Audits and sample size.** Each health benefit plan shall, at least annually, audit its provider directories for accuracy in accordance with 36 O.S. § 6971. Each plan that chooses to audit based on a reasonable sample size of providers shall include in the audit report filed with the Insurance Department the sample size amount and an explanation of the methodology used to determine that the sample size is statistically valid.

(c) **Annual provider directory audit report.**

(1) By March 1, 2025, and by every March 1st thereafter, each insurer of a health benefit plan shall file with the Insurance Department an Annual Provider Directory Audit Report for the preceding calendar year. This Report shall be filed electronically in the manner and form designated by the Insurance Commissioner and in accordance with any instructions posted on the Insurance Department website.

(2) The report shall include at least the following information:

(A) The number of reports of inaccurate information received by each health benefit plan;

(B) The date each report was received;

(C) The date each report was investigated;

(D) The corrective action(s) taken or, if no action is taken, an explanation as to why;

(E) All auditing reports conducted by each plan; and

(F) Any other information the Insurance Commissioner deems necessary.