Regulations Governing Contracting and Management of National Health Insurance Medical Care Institutions

Chapter 1 General Principles

Article 1

These Regulations are enacted pursuant to the principles set forth in Paragraph 1 of Article 66 and Paragraph 1 of Article 67 of the National Health Insurance Act (hereinafter referred to as "the Act").

Article 2

When making contracts and managing an insurance medical care institution, the Insurer shall act on the principle of fairness, equality, respect and mutual trust.

Chapter2 Applications and Reviews of Contracted Service Institutions

Article 3

Medical care institutions with licenses and meet the criteria set out in the Attachment may apply to become a contracted service institution to the Insurer by submitting relevant documents as required by the Attachment.

The Insurer shall complete the review of the submitted application within thirty days. The reviewing period may extend by another thirty days if necessary by informing the applicant.

Physicians managing elementary medical units other than joint clinics, who is qualified for multiple practices, such as physicians, Chinese medicine doctors, and dentists, can only apply to become a contractor for the categories that they are licensed for.

Article 4

The medical care institution or the responsible medical personnel applying to be a contractor will be disqualified should any of the following circumstances occur:

1. Violation of medical care laws, currently under disciplinary suspension, or having unpaid fines;
2. Violations of the laws and regulations governing National Health Insurance (hereinafter referred to as the "Insurance") and as a result, contract suspended or terminated, or fines not paid up in full;
3. Pending issues with the Insurer and refusal to cooperate to seek resolutions;
4. Outstanding debts to the Insurer and refusal to allow the Insurer to deduct such outstanding payments from payable medical costs and expenses;
5. Medical personnel unable to practice due to illness as diagnosed by professional physician(s) and deemed by the Insurer's on the basis of on-site investigations;
6. Failure to renew expired licenses held by medical personnel;
7. Retention of responsible medical personnel(s) or medical personnel still subject to a disciplinary sanction.

Article 5

The medical care institution or the responsible medical personnel applying to be a contractor will be disqualified in five years should any of the following circumstances occur:

1. The institution at the same address sees their franchise contract suspended or terminated twice or more within the last five years;
2. The franchise contract is suspended or terminated again within five years after the completion of the previous franchise contract termination;
3. The franchise contract is terminated or will be terminated for the second time within five years after the completion of the previous contract termination.

No contract shall be granted to any applicant should any of the above situations repeats within five years after given the contract.

It is possible to suspend the contract to specific service items or categories of a medical care institution if such service items or categories are deemed by the Insurer to be in violation of these Regulations based on on-site investigations, or if there are factual violations of the Act, and the situation of violation or related facts sustain.

No contract shall be granted within five years after the five suspensions or terminations of specific service items or categories or three suspensions or terminations of the same service item or category within five years in pursuant to the situations described in each Subparagraph of Paragraph 1.

Article 6

The Insurer shall not pay for any expenses associated with the insurance medical care institution services rendered to the insurance beneficiaries by any medical personnel liable for the actions described in Subparagraphs 2 to 3 of Paragraph 1 of the preceding article.

Article 7

The Insurer shall conclude franchise contracts with insurance medical care institutions which have passed the review of their application for contracting according to the principles set out in Article 2.

The abovementioned contracts shall be in standard form, whose contents shall be reviewed once every year. Any amendment shall be applicable to the following contractual renewals.

Where the circumstances set forth in Articles 38, 39, 40 or 47 are not applicable to medical personnel or practicing physicians, pharmacists (assistant pharmacists), physical therapists (physical therapy technicians), occupational therapists (assistant occupational therapists), medical technologists (medical technicians) and medical radiation technologists (medical radiological technicians) of a medical care institution within five years from the application date for contracting, the effective date of contracting may be fixed retrospectively to the date of the practicing license issued for the medical care institution if the application date is within fifteen working days from the issuance of the said practicing license.

Article 8

The abovementioned contract is valid for three years. Upon expiry of the franchise contract and in the absence of writing notices from the insurance medical care institution to the Insurer to request the

termination of its contracted status, the Insurer may renew the contract in pursuant to the Regulations if the insurance medical care institution meets any of the following criteria:

1. Not in the circumstances described by the Regulations where no contract shall be granted;
2. No received any disciplinary sanctions (contract-violation point) or improvements already made if having been subject to any contract-violation point;
3. Contract suspended but improvements already made after suspension;
4. Fines imposed in accordance to the Act are paid up in full;
5. Not in the circumstances described by Articles 4, 5 and 45.

Article 9

Hospitals applying for the contracting for hospital stays shall be reviewed by hospitals. Mental state restoration medical care institutions applying for the contracting of community rehabilitation services for the mentally ill shall be evaluated and approved by medical care institutions.

The Insurer shall refer to the changed results of assessments on hospitals after the expiry of the previous assessed results, in the review of the insurance payment levels. For any hospitals not accepting further assessments or fail to pass assessments, the contract shall be changed to the elementary medical care units.

The Insurer may refer to the Hospital Accreditation Standards to determine the contract categories for new hospitals not yet evaluated by the central competent authority of health, on the basis of special case, pursuant to relevant laws and regulations.

Insurance medical care institutions other than hospitals shall participate in assessments or investigations organized by the central competent authority of health pursuant to relevant laws and regulations. The contract shall be terminated if the assessment results fail to or the insurance medical care institution refuses to participate in the assessment.

Chapter 3 Regulations Governing Insurance Medical Care Institutions

Article 10

Insurance medical care institutions shall display the designated mark of a contracted medical service institutions in a conspicuous location.

Upon suspension or termination of the contract, insurance medical care institutions shall remove the abovementioned designated mark. However, if the suspension or termination is applicable to specific service items or categories, insurance medical care institutions shall post the notices for the periods and service items or categories suspended or terminated at registration desks (and on the websites) and other conspicuous locations.

Article 11

Insurance medical care institutions shall issue receipts in compliance with the requirements set forth by the Enforcement Rules of Medical Care Act for the medical services rendered to the insurance beneficiaries. The receipts shall list the serial numbers of the insurance certificate of the insurance

beneficiaries for the medical service provided.

Article 12

In the event that a beneficiary fails to provide the NHI IC card or identification document in timely manner for any reason, the insurance medical care institution shall not only provide medical service, but also retain the payment and refund records.

Article 13

Insurance medical care institutions shall not cause insurance beneficiaries to pay for the items covered by the National Health Insurance at their own expenses except for fees provided by Article 14, or purchase medications, treatment materials or pay for inspections at their own expenses, or provide non-gratuitous, un-justified medical services upon the request of insurance beneficiaries and report expenses.

Article 14

In the event that the insurance medical care institution provides a beneficiary with a medical device of difference payment, it shall request the beneficiary for payment in compliance with the following:

1. The payment standard shall be submitted to and approved by the local competent health authority;
2. The item, fee, product features as well as side effects of the medical devise of difference payment and its curative effects compared to the medical devices reimbursed by the Insurance shall be publicized on the website or a place easily seen in the institution.
3. Except in the case of emergency, the relevant manual should be delivered to the patient or the patient's family two days prior to the operation or treatment. In addition, the institution shall give detailed explanations to the patient or the patient's family who should then fill out two counterparts of the consent form to the difference payment in person with one copy held by the patient and the other kept with the patient's medical records; and

The manual set forth in the preceding subparagraph shall clearly stipulate the fee, product features, reasons for use, warnings as well as side effects of the medical device of difference payment and its curative effects compared to the medical devices reimbursed by the Insurance. The consent form shall clearly set out the item name, item code, price listed by the institution, quantity and the difference.

Article 15

Unless in an emergency or due to unexpected surgeries, examinations, or treatments, insurance medical care institutions may not suggest or request patients or their relatives to use the service items not covered by the National Health Insurance when rendering operations, medical checks or procedures to insurance beneficiaries.

Article 16

All entries in account books and records related to the contracted medical care services provided by an

insurance medical care institution shall be consistent with the costs and expenses thereof declared to the Insurer, and shall be placed under custody for a period of five years.

Article 17

If the responsible medical personnel(s) of insurance medical care institutions have become incapable of performing duties for more than thirty days, he/she/they shall report such event to the competent authority that issues their practicing licenses according to relevant laws and regulations. Meanwhile, he/she/they shall report to the Insurer within ten days after the aforesaid thirty days. This clause shall also be complied with upon a change of any matter previously reported to and recorded with relevant competent authorities.

Article 18

In case of name changes of insurance medical care institutions, or changes of the responsible physicians of public medical institutions, the medical institutions of medical legal persons, or medical institutions of legal persons shall report such changes to the Insurer by submitting the practicing licenses issued by the competent authority.

Article 19

The Insurer may conduct on-site investigations to insurance medical care institutions when necessary.

Article 20

When applying for insurance payments for labor, clinics shall obtain approvals from local competent authority for the establishment of operation rooms, labor rooms, infant rooms and observation wards. No Cesarean sections will be covered by the Insurance in the absence of operation rooms.

Article 21

Upon the approval from local competent authority and the consent from the Insurer, insurance medical care institutions may appoint physicians or necessary medical personnel to provide ambulatory medical care services and health rehabilitation diagnoses and treatments in registered old-age care and nursing centers, care institutions or welfare institutions for the mentally and physically challenged and nursing homes (hereinafter collectively referred to as “nursing institutions”) when the following conditions are met:

1. The insurance medical care institutions that provide ambulatory medical care services shall be contracted hospitals and clinics. The service institutions that provide health rehabilitation diagnoses and treatments shall be contracted hospitals and health rehabilitation clinics.
2. When providing health rehabilitation therapies and services, in accordance to the service categories, it is necessary to appoint physicians, physical therapists, occupational therapists, speech or hearing therapists who meet the requirements set forth in Medical Service Payment Items and Standards.
3. Nursing institutions shall be equipped with the diagnosis and treatment facilities as described by the

Standards of the Facilities of Medical Treatment Establishments. When offering health rehabilitation treatments and services, it is necessary to be equipped with the facilities required for physical therapies, occupational therapies, speech or hearing therapies according to the services rendered.

4. It is necessary to file to the Insurer a list of insurance beneficiaries that nursing institutions service. This list shall be renewed once every month.

The Insurer may reject the application from the insurance medical care institution for support services should the aforesaid institution is found to be violating the regulations.

Article 22

The services rendered by the physicians and necessary medical personnel by the insurance medical care institutions specified in the preceding article shall be provided with only in the following timeslots:

1. Ambulatory medical care services and health rehabilitation diagnoses and treatments provided by the physicians of insurance medical care institutions shall be limited to a total of three timeslots each week. Health rehabilitation therapy treatments and services provided by therapists shall be limited to a total of three timeslots each week.
2. Ambulatory medical care services and health rehabilitation diagnoses and treatments provided by the physicians of the insurance medical care institutions offering accommodations to up to 300 mentally or physically challenged patients are limited to a total of six timeslots per week. Health rehabilitation therapy treatments and services provided by therapists shall be limited to a total of six timeslots each week.
3. During the time when the insurance medical care institutions are approved to provide ambulatory medical care services and rehabilitation diagnoses and services in the nursing institutions, other insurance medical care institutions may not apply for the contracting of such services to be rendered to the same nursing institutions.

Notwithstanding, the insurance medical care institution which has insufficient medical departments may request other insurance medical care institutions to form a team in order to offer integrated medical service in nursing institutions. The major insurance medical care institution should be responsible for filing expenses and managing medical records.

In the case of the circumstances set forth in the preceding paragraph, there shall only be one physician and one rehabilitation therapist in any given time period. Notwithstanding, in the case of nursing institutions which provide early treatment, there shall be no more than three rehabilitation therapists who provide treatment service in any given time period.

Article 23

Prescriptions from and artificial limbs installed by physicians working for contracted hospitals in health rehabilitation, orthopedics or cosmetic surgery, as well as physical therapists and occupational therapists, in compliance with the Pharmaceutical Affairs Act, may be covered by insurance. However, the coverage granted before the amendment on September 15, 2010 may be applicable to the regulations before the amendment.

Article 24

Unless in compliance with laws and regulations and with prior reporting to the Insurer and consent from the Insurer, the medical services rendered outside the premise of insurance medical care institutions by physicians of the service institutions are not covered by insurance.

With consent from the Insurer, insurance medical care institutions may dispatch its medical personnel to off-islands and mountains to provide medical services to insurance beneficiaries via medical care tour programs.

Article 25

Insurance medical care institutions may not refuse to provide medical services to insurance beneficiaries without any legitimate causes, nor can they demand earnest money from insurance beneficiaries.

Article 26

The transfers and referrals of insurance beneficiaries by insurance medical care institutions shall be based on medical requirement.

Insurance medical care institutions shall administer appropriate procedures and provide proper assistance to insurance beneficiaries when their conditions are stabilized and they are discharged from the hospital or transferred to chronic care wards.

Article 27

Contracted hospitals or clinics may delegate contracted medical laboratories or radiological test centers to perform tests, inspections and examinations.

Contracted physical therapy clinics or occupational therapy shall provide medical services in accordance with the Physical Therapists Law or Occupational Therapists Act. Such medical services shall be based on the prescriptions by physicians of contracted hospitals or clinics in health rehabilitation department, neurology department, orthopaedics department, neurosurgery department, plastic surgery department or general medicine department.

The physicians in general medicine mentioned above shall be recognized by the Insurer to have specialty in Rheumatism.

Occupational therapies in Paragraph 2 may also be based on the prescriptions of psychiatrists.

Article 28

Home nursing care provided by the nursing homes with practicing licenses for home nursing care to insurance beneficiaries living in the accommodation of the nursing homes may be covered by the insurance.

Chapter 4 Establishment of Insured Wards

Article 29

Acute care wards mentioned in Article 47 refer to the wards with the sickbeds for patients suffering from acute diseases, quarantine diseases, special diseases and psychiatric acute diseases.

Article 30

Chronic care wards mentioned in Article 47 refer to the wards for patients suffering from chronic diseases (including chronic tuberculosis, Hansen's disease) or chronic psychiatric diseases.

Article 31

Contracted hospitals shall register their wards at the local competent authority of health, and report such details to the Insurer for recordation purposes.

Article 32

Insurance wards mentioned in Paragraph 1 of Article 67 refer to the wards for the patients not charged for the difference in ward fees in contracted hospitals.

Insurance medical care institutions may not charge insurance beneficiaries the difference in ward fees except for the following wards:

1. An acute care ward with two sickbeds or less.
2. A chronic care ward with two sickbeds or less.

Article 33

The number of insurance wards sickbeds shall account for at least 75% of the total amount of sickbeds for the contracted medical centers of public hospitals, regional hospitals and local hospitals. The number of insurance wards sickbeds shall account for at least 60% for non-public hospitals.

The above ratios shall be calculated separately for acute care wards and chronic care wards. Failure to meet the requirements for facilities shall be rectified within six months by submitting a proposal to the Insurer.

Article 34

Contracted hospitals shall clearly display, at the in-patient registration desks and on the websites, the total number of sickbeds, the number of occupied and available sickbeds for different types of wards, the number and percentage of sickbeds in insurance wards, the number of sickbeds in the wards for which price differences are charged and the total difference charged. Such data shall also be displayed at ward nursing stations in conspicuous locations.

Chapter 5 Management of Insurance Medical Care Institutions

Article 35

The Insurer shall inform insurance medical care institutions to make improvements for any of the following circumstances:

1. Failure to register insurance certificates and upload medical data of insurance beneficiaries in

accordance with the Regulations Governing the Medical Services Covered under National Health Insurance.

2. Failure to assist insurance beneficiaries in applying for the coverage by labor insurance for occupational diseases and accidents and the subrogation right under the compulsory automobile liability system by issuing the necessary receipts or assisting in filing.
3. Non-purposeful errors in data filed for the survey of medicine prices.
4. Other non-major breach of the terms and conditions of the franchise contract.

Article 36

The Insurer may impose one contract-violation point to the insurance medical care institutions for any of the following circumstances:

1. Patient transfer not conducted in accordance with medical laws or laws and regulations in relation to the National Health Insurance;
2. Violation of Articles 10 to 14, Articles 16 to 17, Article 25, Paragraph 2 of Article 32, Article 33 or Article 34;
3. Failure to audit the medical papers of insurance beneficiaries in accordance with the Regulations Governing the Medical Services Covered under National Health Insurance. Notwithstanding, the above may not apply to the case where the NHI IC card is later submitted for inspection after emergency treatment is given.
4. Failure to return the medical expenses paid by insurance beneficiaries at their own expenses, as stipulated by the Regulations;
5. Failure to charge insurance beneficiaries the fees they shall pay at their own expenses or declare medical expenses, as stipulated by the Regulations;
6. Improper solicitation of patents for accepting medical services covered by the insurance and such behavior penalized by the health competent authority;
7. Improper request for difference payment from a beneficiary with the difference exceeding the maximum benefit set by the Insurer;
8. In violation of Article 73 of the Act; or
9. Failure to rectify the situation within the deadline set forth by the Insurer.

Article 37

The Insurer may deduct ten times of the reported medical expenses by the insurance medical care institutions based on the average total value of the most recent quarter of their locations should the insurance medical care institutions be found under any of the following circumstances:

1. Failure to provide medical services according to prescriptions, medical history or other records;
2. Provision of medical services without diagnoses from physicians;
3. Prescriptions or medical expenses reported not recorded in medical history or records;
4. Failure to produce medical history or records to facilitate the reporting of medical expenses;
5. Declaration of medical expenses knowing that patients use insurance certificates of others;

6. Retention of personnel who are not qualified medical personnel to conduct medical personnel' s duties other than those of physicians;

The Insurer may directly deduct the medical expenses payable to the insurance medical care institutions for the abovementioned deductions.

Article 38

The Insurer shall suspend the contract for one month if the insurance medical care institution has any of the following circumstances during the term of the contract. Notwithstanding, in the case of contracted hospitals, the Insurer may suspend the medical department or specific service item which violates the requirement, or the outpatient, inpatient services in whole or in part for one month in accordance with the seriousness of the violation.

1. Violation of Article 68 or Paragraph 1 of Article 80 and again after three disciplinary actions by the Insurer;
2. Violation of Article 36 and subject to the punitive measure of three contract-violation points and the same violation again;
3. One of the subparagraphs in the preceding article after medical expenses being deducted three times;
4. Refusal to provide appropriate medical services to insurance beneficiaries and such offense being significant;

Article 39

The Insurer may suspend the contract for one to three months if the contracted insurance medical care institution has any of the following circumstances during the term of the contract. Notwithstanding, in the case of contracted hospitals, the Insurer may suspend the medical department or specific service item which violates the requirement, or the outpatient, inpatient services in whole or in part for one to three months in accordance with the seriousness of the violation.

1. Declaration of medical expenses incurred by non-beneficiaries in the name of beneficiaries;
2. Provision of medications, nutrient supplements or other items not necessary for treatments to beneficiaries, registration of unnecessary medical services and declaration of medical expenses;
3. Falsifying medical expenses by forging medical records with no diagnosis or treatment rendered;
4. Other unscrupulous behavior or false certifications, reports or statements in order to declare medical expenses; or
5. Retention of personnel who are not qualified physicians to provide medical services for beneficiaries and declaring medical expenses by the contracted medical care institution.

Article 40

The Insurer shall terminate the contract if the contracted insurance medical care institution has any of the following circumstances. Notwithstanding, in the case of contracted hospitals, the Insurer may suspend the medical department or specific service item which violates the requirement, or the outpatient, inpatient services in whole or in part for one year in accordance with the seriousness of the

violation.

1. Insurance medical care institutions or their responsible medical personnel has been suspended pursuant to the preceding Article and the same offence was found within five years after the completion of such suspension;
2. Unscrupulous behavior or false certifications, reports or statements to declare medical expenses and such offense being significant;
3. Violation of medical laws and regulations, and practicing licenses revoked by the competent health authority;
4. The contracted insurance medical care institution retains personnel who are not qualified physicians to provide medical services for beneficiaries and declare medical expenses, which is deemed as a serious violation.
5. Reporting of false dates in order to declare the expenses for medical services rendered to insurance beneficiaries during the period when the contract is suspended; or requesting other insurance medical care institutions to declare such expenses;
6. Contract terminated or suspended for a year pursuant to the above subparagraphs 1-5, and aforesaid offenses found within one year of resumed contracting after the previous contract termination or suspension of the contract.

No application for contracting is permitted within one year after the termination of the contract pursuant to the preceding paragraph.

Article 41

Where the Insurer has imposed disciplinary actions on the contracted insurance medical care institution which has the conduct set forth in Paragraph 1 of Article 81 of the Act pursuant to Subparagraphs 2 and 4 of Paragraph 1 of the preceding article, the Insurer shall publicize the name of the institution, the name of the responsible medical personnel or the person committing the violation as well as the facts of the violation on its website between the issuance of the disciplinary letter and the termination of the disciplinary actions.

Article 42

Where the suspension or termination of a contract pursuant to Articles 38 to 40 poses a threat of significant impact on the beneficiaries' right to receive medical care, or is necessary to prevent or mitigate risks to the public, the contract insurance medical care institution, subject to the Insurer's approval and within the scope of disciplinary, may apply to the Insurer for the deduction of the payment to offset the suspended or terminated contract period according to the declared volume of the medical department or specific service item which is subject to the disciplinary actions or the outpatient, inpatient services in whole or in part as well as the verified average points of the total volume of the district of the most recent year.

The preceding paragraph governing contractual suspension or termination is applicable to the pending cases not yet implemented before the effect data of the Regulations on September 15, 2010.

Article 43

Significant offenses referred to in Subparagraphs 2 and 4 of Paragraph 1 of Article 40 of any of the following circumstances:

1. Falsely reported points exceed 100,000 and the provision to insurance beneficiaries with medicine, nutrient supplements or other items that are not medically necessary.
2. Falsely reported points exceed 100,000, the collection of insurance certificates and the false declarations of medical records and medical expenses for insurance beneficiaries not treated.
3. Falsely reported points exceed 150,000 and false declarations of hospital stay of insurance beneficiaries.
4. Falsely reported points exceed 250,000

Article 44

If the operations of insurance medical care institutions are suspended by the competent health authority as a result of the violation of medical care laws and regulations, the contract shall be suspended during this period. If the operations of insurance medical care institutions are terminated or relocated, the contract shall be terminated. However, this does not apply to the situations whereby a notice has been sent to the Insurer with changed practicing licenses of the same insurance medical care institution moving to another address in the same township, district or city.

Article 45

Contract shall be terminated should insurance medical care institutions be found under either of the following circumstances:

1. Violation of medical care laws and regulations, the practicing licenses were accordingly revoked by the health competent authority.
2. Subparagraph 2 or Subparagraph 3 of Paragraph 1 of Article 5.

Article 46

Article 37 to 40 may not apply in the event that the contracted insurance medical care institution voluntarily reports to the Insurer of any incorrect information in its filed declaration or confesses to other authorities by returning the relevant expenses (or deductions) prior to the inspection visit conducted by the Insurer or other agencies. The same shall apply to the responsible medical personnel or the medical personnel liable for the conduct who have the above circumstance.

Article 47

For any insurance medical care institution whose contract is suspended or terminated, the responsible or liable medical personnel shall not be reimbursed for the services of medical services they provide to insurance beneficiaries during suspension or within one year after termination.

The medical personnel whose expenses are not reimbursed are deemed to be subject to the disciplinary

act of contract suspension or termination.

Article 48

If insurance medical care institutions do not accept the disciplinary actions taken by the Insurer pursuant to the Regulations, they may request in writing for a second review within thirty days after they have received the notice. However, such request can only be made once.

The Insurer shall revisit the pending case within thirty days after the aforesaid application has been received. They shall change or rescind the original decision if the reason is justified.

Chapter 6 Supplementary Provisions

Article 49

If there is any outstanding insurance premiums and/or any overdue charges due from insurance medical care institutions, and such an outstanding debt remain unpaid after follow-up notices, the Insurer shall be entitled to offset the overdue outstanding with payable medical costs and expenses.

Article 50

Where the franchise contract has been suspended or terminated prior to the effective date of the amended Regulations on December 30, 2002, such suspension or termination event shall not be included in the accumulation of the times of contract suspension or termination as required in Subparagraph 2 of Article 45.

The calculation of the times of contract suspension or termination pursuant to Subparagraphs 2 and 3 of Paragraph 1 of Article 5, Paragraph 4 of Article 5, and Subparagraph 2 of Article 45 for the cases before the effective date of the amended Regulations on September 15, 2010 is on the basis of one time per insurance medical care institution or its medical personnel. Contract suspension is not included if the disciplinary action covers both contract suspension and termination.

Article 51

In rendering the disciplinary decision according to these regulations, adequate consideration shall be accorded to the violation of legal obligation, purpose, degree of fault, and implications as the basis of the handling of breach of contract.

Article 52

These Regulations shall come into force on January 1, 2013.

Attachment: List of Documents Required for Medical Care Institutions Applying for National Health Insurance Contracts

Institutions / Documents	1	2	3	4	5	6	7	8	9	10	11
	Hospital and clinic	Pharmacy	Medical laboratory	Radiological medical institution	Physical therapy clinic	Occupational therapy clinic	Licensed home-care nursing institution	Home-care nursing institution	Midwifery institution	Mental rehabilitation institution	Home respiration care institution
1	Application form										
2	ID of responsible medical personnel (person)										
3	Status credential(s) of the responsible physician Business operation permit and the practicing license of the responsible person										
4	Except for a newly established hospital, hospitals applying for operating the hospital care activities shall submit the relevant certificates evidencing the rated grade of the applicant hospital.			Certificates for radioactive material and equipment capable of producing ionizing radiation							
5	Practicing license and ID of the medical care personnel employed by the applicant, and the practicing seniority certificate of the relevant responsible medical care personnel of the applicant duly recognized by the competent health authority, and	Practicing licenses and ID of pharmacists employed by the applicant	Practicing licenses and ID of medical examiners employed by the applicant; practicing licenses and ID for radiologists or radiological technicians	Practicing licenses and ID of radiologists or radiological technicians employed by the applicant;	Practicing licenses and ID of physical therapists employed by the applicant	Practicing licenses and ID of occupational therapists employed by the applicant	Practicing licenses and ID of medical personnel employed by the applicant		Practicing licenses and ID of medical personnel employed by the applicant	Practicing licenses and ID of medical personnel employed by the applicant	Practicing licenses and ID of medical personnel employed by the applicant

	conforming to the relevant requirements set out in these Regulations		employed by the applicant for the radiological department	practicing licenses and ID for medical examiners or technicians employed by the applicant for the medical examination laboratory						
6	A bank account opened at a financial institution under the name of the responsible physician and the medical care institution filing the application. If the applicant is a medical care institution organized in the form of a juristic person, the said bank account shall be opened under the name of the institution. If the applicant is a public	A bank account opened at a financial institution under the name of the responsible pharmacist or pharmaceutical technician and the medical care institution filing the application	A bank account opened at a financial institution under the name of the responsible medical examiner or technician and the medical care institution filing the application	A bank account opened at a financial institution under the name of the responsible radiological technologist or radiological technician and the medical care institution filing the application	A bank account opened at a financial institution under the name of the responsible physical therapist and the medical care institution filing the application	A bank account opened at a financial institution under the name of the responsible occupational therapist and the medical care institution filing the application	A bank account opened at a financial institution under the name of the responsible person and the medical care institution filing the application. If the applicant is a medical care institution organized in the form of a juristic person, the said bank account shall be opened under the name of the institution. If the applicant is a public medical care institution, the said bank account shall be opened under the name of the institution or of the exclusive holder of an exchequer	A bank account opened at a financial institution under the name of the responsible midwife and the medical care institution filing the application	A bank account opened at a financial institution under the name of the responsible person and the medical care institution filing the application. If the applicant is a medical care institution organized in the form of a	A bank account opened at a financial institution under the name of the responsible person and the medical care institution filing the application. If the applicant is a medical care institution organized in the form of a

	medical care institution, the said bank account shall be opened under the name of the institution or of the exclusive holder of an exchequer account.								juristic person, the said bank account shall be opened under the name of the institution. If the applicant is a public medical care institution, the said bank account shall be opened under the name of the institution or of the exclusive holder of an exchequer account.	juristic person, the said bank account shall be opened under the name of the institution. If the applicant is a public medical care institution, the said bank account shall be opened under the name of the institution or of the exclusive holder of an exchequer account.
7	A payment transfer account data card set up with Post Office									
8	A tax withholding agency incorporation (alteration) registration application									
9	Purchase certificates of relevant computer equipment used for registering insurance certificates and a safety module application form									
10	Other relevant documents as required for filing a contracted medical care institution qualification application									