§ 4806. Health care facility applications. (a) An insurer that offers a managed care product shall, upon request, make available and disclose to facilities written application procedures and minimum qualification requirements that a facility must meet in order to be considered by the insurer for participation in the in-network benefits portion of the insurer's network for the managed care product. The insurer shall consult with appropriately qualified facilities in developing its qualification requirements for participation in the in-network benefits portion of the insurer's network for the managed care product. An insurer shall complete review of the facility's application to participate in the in-network portion of the insurer's network and, within sixty days of receiving a facility's completed application to participate in the insurer's network, shall notify the facility as to: (1) whether the facility is credentialed; or (2) whether additional time is necessary to make a determination because of a failure of a third party to provide necessary documentation. In such instances where additional time is necessary because of a lack of necessary documentation, an insurer shall make every effort to obtain such information as soon as possible and shall make a final determination within twenty-one days of receiving the necessary documentation.

(b) For the purposes of this section, "facility" shall mean a health care provider that is licensed or certified pursuant to article five, twenty-eight, thirty-six, forty, forty-four, or forty-seven of the public health law or article sixteen, nineteen, thirty-one, thirty-two, or thirty-six of the mental hygiene law.