

**APPENDIX RR. APPLICATION FOR REGISTRATION AS AN INDEPENDENT
REVIEW ORGANIZATION [NEW]**

Oklahoma Insurance Department
 Five Corporate Plaza
 3526 NW 56th Street, Suite 100
 Oklahoma City, OK 73112
 405-521-2828

Initial Application
 Renewal

Application for Registration as an Independent Review Organization

Type of Entity: Corporation Partnership LLC Other _____

Contact Information for Application

Legal Name of Applicant	State of Domicile	Federal EIN	
Contact Person (Name and Title)	Phone ()	Email	
Business Address (Do not use PO Box)	City	State	Zip
Mailing Address (if different from business address)	City	State	Zip

Contact Information for Initiating External Reviews (also to be made available to carriers and consumers)

Contact Person (Name and Title) or Department	Phone ()	Email	
Mailing Address	City	State	Zip
Website	Toll-Free Telephone Number	Fax ()	
Other Contact Information			

Applicant Attestation and Certification

Applicant certifies that it will notify the Oklahoma Insurance Department immediately if its accreditation is lost with the American Accreditation Healthcare Commission/URAC. Applicant acknowledges that the Oklahoma Insurance Department may terminate this license if the applicant loses accreditation or no longer satisfies the minimum requirements for licensure.

Applicant acknowledges that payment of any fees associated with any external reviews conducted pursuant to 36 O.S. § 6475.1 et seq. are the sole responsibility of the health carrier whose medical decision is being reviewed. Applicant understands that it has no recourse against the Oklahoma Insurance Department or the state of Oklahoma to the extent that any health carrier fails to pay any medical reviewer fees. Applicant authorizes the Oklahoma Insurance Department to verify information with any federal, state, or local government agency, insurance company or accrediting organization.

Applicant acknowledges and represents that it understands and will comply with Oklahoma’s insurance laws and the rules of the Oklahoma Insurance Department. Applicant hereby represents that it will comply with all requirements imposed under 36 O.S. § 6475.1 et seq. and assures that no conflict of interest or improper controlling interest as outlined in the statute exists. Applicant further agrees to maintain and provide to the Oklahoma Insurance Department the information set out in 36 O.S. § 6475.15.

I certify that, under penalty of perjury, I am the person named herein and know the contents thereof, and that all of the information submitted in this application and its attachments is true and complete. I attest that I have the authority and capacity to execute this certification on behalf of the applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

Signature of person who completed application

Signature of Officer, Director, or Board Member

Printed Name

Printed Name

Title

Title

Date

Date

Please provide the following documents:

1. A copy of the most recent certificate from American Accreditation HealthCare Commission/URAC for Independent Review Organizations.
2. A schedule of fees.
3. A copy of the current Certificate of Authority provided by the Oklahoma Secretary of State.

Please submit this application and all required attachments to:

Oklahoma Insurance Department
External Review Program
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112

[Added at 29 Ok Reg 1275; eff 7-14-12]