

## APPLICATION FOR REGISTRATION AS AN INDEPENDENT REVIEW ORGANIZATION

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

### 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 as separate attachments:

1. A narrative description and an organizational chart to provide an overview of the applicant's operations.
2. A list of names and official capacities of all persons responsible for the applicant's external review program, including:
  - a. all members of the governing body, the officers and directors of a corporation, and the partners or associates of a partnership or association; and,
  - b. disclosure of any contracts or arrangements between those persons and the applicant, including any appearance of a conflict of interest as specified in 36 O.S. 6475.13.
3. A written statement addressing the determination of any conflicts of interest involving the applicant and all clinical reviewers.
4. A copy of your most recent certificate from American Accreditation HealthCare Commission/URAC for Independent Review Organizations.
5. A list of specific areas of clinical expertise in which you conduct independent reviews, if applicable.
6. A schedule of fees.
7. A copy of your current Certificate of Authority provided by the Oklahoma Secretary of State.
8. A narrative description of the quality assurance mechanism in place to meet the requirements of 36 O.S. 6475.13(A)(1).
9. A narrative description of the process utilized to maintain the confidentiality of personally identifiable health information and of clinical reviewers' and contract specialists' identities.
10. A copy of the policy and procedures that govern all aspects of the external review process for both standard and expedited reviews, including experimental and investigational treatments.

Please submit this application and all required attachments to:

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