

**INDEPENDENT REVIEW ORGANIZATION**  
**APPLICATION and Checklist**

UTAH INSURANCE DEPARTMENT  
SUITE 3110 STATE OFFICE BUILDING  
SALT LAKE CITY UT 84114  
801 538-3800

(1) Name of Applicant: \_\_\_\_\_

Street Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Toll Free Number \_\_\_\_\_

Email Address: \_\_\_\_\_ Website Address \_\_\_\_\_

Fax Number: \_\_\_\_\_ FEIN Number: \_\_\_\_\_

(2) Name of Contact Person for Regulatory Matters: \_\_\_\_\_

(3) Form of Organization:

Proprietorship

Partnership

Corporation (State & Date of Incorporation: \_\_\_\_\_)

Other (Describe: \_\_\_\_\_)

(4) Is the organization registered with the Utah Corporations Division  Yes  No

State of incorporation: \_\_\_\_\_

(5) Registered Agent for Service of Process in Utah:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_\_) \_\_\_\_\_

(6) Has the applicant ever had an application denied by any state regulatory authority?  Yes  No Explain if yes: \_\_\_\_\_

(7) Has the applicant ever been the subject of regulatory action?

Yes  No Explain if yes: \_\_\_\_\_

(8) Has the applicant ever lost accreditation to perform independent reviews?

Yes  No Explain if yes: \_\_\_\_\_

(9) Has the applicant ever changed its name?

Yes  No Explain if yes: \_\_\_\_\_

(10) Does the applicant own or control, or is owned or controlled by, an insurer, health benefit plan, trade association, or health care provider?

Yes  No Explain if yes: \_\_\_\_\_

(11) Does any clinical reviewer employed by or contracted with the applicant have a history of being the subject of disciplinary action?

Yes  No Explain if yes: \_\_\_\_\_

(12) Does the applicant have a toll-free telephone service to receive information on a twenty-four basis?

Yes  No Explain if no: \_\_\_\_\_

(13) Do the clinical reviewers assigned by you meet the requirements of a clinical reviewer as defined in R590-261-4 (2)?

Yes  No Explain if no: \_\_\_\_\_

The following information may be submitted on a separate sheet and is considered to be part of the application:

(14) For each officer, director and controlling person<sup>1</sup> of the applicant, complete a biographical affidavit using the NAIC template located at [http://www.naic.org/documents/industry\\_ucaa\\_form11.doc](http://www.naic.org/documents/industry_ucaa_form11.doc).

(15) Provide a detailed description of the procedures used by the applicant to insure that the identity, financial information, and medical information of a claimant is not disclosed.

(16) Describe the applicant's written policies and procedures that govern all aspects of both the standard independent review and the expedited independent review process, including the procedures to ensure:

(a) that an independent review is conducted within the specified time frame and that a required notice is provided in a timely manner;

(b) the selection of a qualified and impartial clinical reviewer to conduct the independent review and suitable matching of the reviewer to a specific case; and

(c) that any individual employed by or under contact with the independent review

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<sup>1</sup> A Controlling Person is any person who is a partner (other than a limited partner), officer, director, or anyone having an ownership interest of 10% or more of the organization whether that person is an individual or other entity.

organization adheres to all requirements.

(17) Describe the applicant's quality assurance program.

(18) Describe the policies and procedures that the applicant will follow to ensure the independence of the independent review organization and the clinical reviewer.

(19) List all accreditations for the applicant and attach a copy of each.

**CERTIFICATION**

I certify that I have read and am familiar with the requirements of the Utah Insurance Code and rules regarding independent review organizations and that this independent review organization meets all requirements to qualify as an independent review organization in the State of Utah. I further certify that the information provided in this application is true, complete, and correct to the best of my knowledge and belief.

Date: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

Printed Name & Position: \_\_\_\_\_

Utah Insurance Department  
Independent Review Organization  
Application Checklist

NAME: \_\_\_\_\_

**INSTRUCTIONS:** This checklist is to be completed and attached to the cover of your application. Initial each item included with the application.

\_\_\_\_\_ (1) Biographical affidavit for each officer, director and controlling person<sup>2</sup> of the applicant.

\_\_\_\_\_ (2) Detailed description of the procedures used by the applicant to ensure that the identity, financial information, and medical information of a claimant is not disclosed.

\_\_\_\_\_ (3) Description of the applicant's written policies and procedures that govern all aspects of both the standard independent review and the expedited independent review process.

\_\_\_\_\_ (4) Description of the applicant's quality assurance program.

\_\_\_\_\_ (5) Description of the policies and procedures that the applicant will follow to ensure the independence of the independent review organization and the clinical reviewer.

\_\_\_\_\_ (6) Application fee of \$250.00.

\_\_\_\_\_ (7) Copy of applicant's accreditation as an independent review organization.

Date: \_\_\_\_\_ Authorized Signature: \_\_\_\_\_

Printed Name & Position: \_\_\_\_\_

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