**Section 4520.EXHIBIT B Application for Registration of a Utilization Review Organization**

|  |  |  |
| --- | --- | --- |
| 1. | Name of Applicant |  |
|  | Type of Applicant (check one): |
|  | [ ]  | Corporation |
|  | [ ]  | Partnership |
|  | [ ]  | Limited Liability Corporation |
|  | [ ]  | Other (Describe) |  |
|  | FEIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Contact Person |  |
|  | Business Telephone Number | ( ) |  |
|  | Fax Number | ( ) |  |
|  | Email Address |  |  |
| 2. | Type of Utilization Review Organization (check **all** that apply): |
|  | [ ]  | Health Care Utilization Review (as defined in Section 4520.30 of this Part) |
|  | [ ]  | Workers' Compensation Review (as defined in 50 Ill. Adm. Code 2905.10) |
|  | Check **all** categories that apply (as applicable): |
|  | [ ]  | Licensed HMO providing utilization review services outside of the HMO (as defined in 50 Ill. Adm. Code 4521.20) |
|  | [ ]  | Licensed HMO providing utilization review services only within that HMO (as defined in 50 Ill. Adm. Code 4521.20) |
|  | [ ]  | Third Party Administrator |
|  | [ ]  | Licensed Insurance Company providing utilization review services outside of that Insurance Company |
|  | [ ]  | Licensed Insurance Company providing utilization review services only within that Insurance Company |
|  | [ ]  | Hospital or Medical Group providing utilization review services for other than internal purposes |
|  | [ ]  | Workers' Compensation Utilization Review Organization |
|  | [ ]  | Other (Describe) |  |  |
| 3. | Business Address |
|  | Street (do not use PO Box) |  |
|  | City |  | State |  | Zip |  | - |  |
| 4. | Mailing Address |
|  | Street or P.O. Box |  |
|  | City |  | State |  | Zip |  | - |  |
| 5. | Business Telephone Number | ( ) |  |
|  | Toll Free Number | ( ) |  |
|  | FAX Number | ( ) |  |
|  | Email Address/Website |  |  |
| 6. | Agent for Service of Process **in Illinois** |
|  | Name |  |
|  | Street Address (do not use P. O. Box) |  |
|  | City |  | State |  | Zip |  | - |  |
| 7. | For each Utilization Review Program supply the following information: |
|  | a) | The name, address, telephone number and normal business hours of the utilization programs. |
|  |
|  | b) | The organization and governing structure of the utilization review programs. |
|  |
|  | c) | The number of reviews in Illinois for which utilization review is conducted by each utilization program for the current year. |
|  |  | [ ]  | Health Reviews |
|  |  | [ ]  | Workers' Compensation Reviews |
|  |
|  | d) | Hours of operation of each utilization review program. |
|  |
|  | e) | Description of the grievance process for each utilization program. |
|  |
|  | f) | Please check (all that apply) to determine if you are using the Health Standards and/or the Workers' Compensation Standards in order to meet or exceed American Accreditation Healthcare Commission (URAC) Standards and provide the Department with a copy of your current certificates, if applicable.  |
|  |  | [ ]   | Health Utilization Standards |
|  |  | [ ]   | Workers' Compensation Standards |
|  |
|  | g) | Number of reviews in Illinois for which utilization review was conducted for the previous calendar year for each utilization review program. |
|  |  | [ ]  | Health Reviews |
|  |  | [ ]  | Workers' Compensation Reviews |
|  |
|  | h) | Written policies and procedures for protecting confidential information according to applicable State and Federal laws for each utilization review program. |
|  |
|  | i) | Biographical information for organization officers and directors, as set forth in Exhibit C or D (as appropriate). Biographical affidavits shall be stamped "confidential" by the utilization review organization. |
| 8. | Indicate accreditation status below. |
|  | a) | [ ]  | Health accredited by: |  |
|  | [ ]  | URAC |
|  | [ ]  | NCQA |
|  | [ ]  | JCAHO |
|  | b) | [ ]  | Workers' Compensation accredited by: |  |
|  | [ ]  | URAC Health Standards |
|  | [ ]  | URAC Workers' Compensation Standards |
|  | c) | [ ]  | Unaccredited |  |
| 9. | [ ]  | Check Enclosed |
|  | a) | [ ]  | Accredited fee $1500 biennially |
|  | b) | [ ]  | Unaccredited fee $3000 biennially |
| 10. | Affirmation (to be signed by an officer or director of the utilization review organization only): |
|  |  |
|  | I, |  | do hereby certify that |
|  |  | (typed name, title) |  |
|  |  |
|  | (utilization review organization) |
|  | complies with the Health and/or Workers' Compensation Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health and/or Workers' Compensation Utilization Management Standards, and do hereby affirm that all of the information presented in this application is true and correct. |
|  |  |  |  |
|  | (signature) |  | (date) |

Please mail completed application to:

Illinois Department of Insurance

Utilization Review Unit

320 West Washington Street

Springfield IL 62767-0001

(217) 558-2309

(Source: Amended at 34 Ill. Reg. 6879, effective April 29, 2010)