South Carolina Department of Insurance

1201 Main Street, Suite 1000
Columbia, South Carolina 29201

P.O. Box 100105
Columbia, SC 29202-3105
Telephone: (803) 737-6134

MARK SANFORD
Governor

SCOTT RICHARDSON
Director of Insurance

Utilization Review / Private Review Agents
Certificate of Registration Application

This **Application** is made by:

Contact Person: _____ Telephone Number: _____

1. Business Name: _____

2. Applicant is the following type business entity (check only one entity):

☐ **Individual** ☐ **Corporation** ☐ **Partnership**

a. If applicant is a corporation or partnership, identify the majority owner and percentage of ownership.

_____

b. If applicant is a partnership, attach a copy of the partnership agreement.

NOTE: This Private Review Agent's certificate is non-transferable. If the business is sold, or a transfer of majority ownership occurs, the certificate hereinafter issued must be returned, and the surviving business must apply for a new certificate.

3. Business Street Address: _____
Street (Do Not Use a Post Office Box)

City: _____ State: _____ Zip Code: _____

4. Business Mailing Address: _____
Street or Post Office Box

City: _____ State: _____ Zip Code: _____

5. Business Telephone Number: _____

6. If applicant is a Corporation, provide State of Incorporation: _____

a. Attach a copy of Certificate of Authority from State of Incorporation.

b. Attach a letter of good standing from State of Incorporation.

c. Attach a copy of Articles of Incorporation.

7. List all other locations, providing complete addresses and telephone numbers:

PO Box/Street	City	State Zip Code	Telephone No.
PO Box/Street	City	State Zip Code	Telephone No.

(Attach a separate sheet to this **Application** if necessary.)

8. If applicable, provide the names of all partners or all officers. Include the social security numbers and birth dates of all individuals.

Name	Social Security Number	Birth Date

(Attach a separate sheet to this **Application** if necessary.)

9. Provide the applicant's hours of operation within the State of South Carolina (Eastern Standard Time): _____

a. Please list toll free number for accessibility: _____

b. Please show number of incoming telephone lines: _____

c. Show incoming call queue time: _____

10. By Attachment Number One, provide an accessibility plan of operation for weekends and holidays.

11. By Attachment Number two, provide both a list indicating the total of all reviewing personnel, by specific qualification or specialty. Additionally, include a total of all physicians, by specialty, which support and/or supervise reviewing personnel.

12. By Attachment Number Three, provide the total number of covered lives for which the reviewing personnel of your company may be required to perform utilization review activities.

13. At Attachment Number four, provide a copy of all materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under each contract.

14. By Attachment Number five, provide the applicants procedures for notification of an adverse decision. Include all forms used in this adverse decision notification process.

15. By Attachment Number Six, provide the applicant's appeal procedures by which insured and providers may seek reconsideration of determinations by the applicants utilization review personnel. Include all appropriate forms used within the appeals process.

16. By Attachment Number seven, provide the applicants internal procedures currently in place to protect the confidentiality of individual medical records. Specifically list all state and federal laws, which were reviewed by the applicant to develop these procedures.

17. Has the applicant, or any one of its incorporators, owners, partners, officers, or employees Performing utilization reviews, ever had an application for a private review agents license or similar license, denied, revoked, or suspended, or been fined: or had any professional, vocational, or business license denied, suspended, or revoked by any public authority in this or in any other state? _____ If the answer to Question 17 is yes, then provide the complete details by Attachment Number Eight.

18. If applicant has been reviewed by URAC, please attach a copy of the most recent report and Certification.

19. Attach a bank check made payable to the South Carolina Department of Insurance in the total amount of $1200.00 (NON-REFUNDABLE). This amount includes a $400.00 original application fee and an $800.00 biennial registration fee.

20. The applicant, being first duly sworn, states that he has completed this application or that he has read this application and knows its contents and its attachments; that to the best of his knowledge and belief the statements made upon this application and upon all attachments are true, correct, and complete in every material respect, and do not contain any statement which, under the circumstances under which it was made, would be false or misleading in respect to any material fact: and that he has read and understands the laws of the State of South Carolina pertaining to utilization reviews and private review agents.

If the Applicant is a Corporation:

President or Chief Executive Officer:

Signature _____ (Please type President or Chief Executive Officer's name.) _____

Secretary:

Signature _____ (Please type Secretary's name.) _____

If the applicant is a partnership:

Partner:

Signature _____ (Please type Managing General Partner's name.) _____

If the applicant is an individual:

Individual:

Signature _____ (Please type Individual's name.) _____

Subscribed and sworn to me before this
_____ Day of _____, _____

_____

My Commission Expires: _____

County of _____ (A Notary Seal Must Be Affixed Here.)

State of _____

Form SCDI 2510