



**The State of New Hampshire**  
**Insurance Department**  
21 South Fruit Street, Suite 14  
Concord, NH 03301

**APPLICATION FOR LICENSE AS A MEDICAL UTILIZATION REVIEW ENTITY**

Application is hereby made on behalf of the medical utilization review entity herein named for a license authorizing it to transact business and to otherwise perform as a medical utilization review entity in New Hampshire.

Legal Name of the Medical Utilization Review Entity (If the name is not in English, state it and give an exact literal translation):

\_\_\_\_\_

Medical utilization review entity's FEIN or Social Security Number: \_\_\_\_\_

This application is for (check one):  New License  Renewal

Applicant's Street Address: \_\_\_\_\_

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

Person and mailing address where license should be mailed: \_\_\_\_\_

\_\_\_\_\_

Applicant is a (check one):  Sole Proprietorship  Partnership  Corporation

Other, please specify: \_\_\_\_\_

a. If the applicant is a corporation, please specify the state of incorporation:

\_\_\_\_\_

b. List all states in which the corporation does business: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Required Information

Licensing Contact: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

List the principal proprietors, partners, directors, officers and administrators. Also, include any others responsible for the operation, management and control of the applicant. Include name and title. Attach a separate sheet of paper, if necessary.

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Attach separate sheets of paper giving biographical sketches of all persons listed above. Include, at least, the person's current home address, current position(s), education and previous experience.

The applicant has \_\_\_\_\_ employees in New Hampshire and \_\_\_\_\_ employees nationally.

List all locations from which operations are conducted whether in or outside of New Hampshire. Show the range of activities and the number of employees at each location. Include City/State, Activities, and Number of Employees. Attach a separate sheet if necessary.

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**IT IS REQUESTED THAT THE APPLICANT PROVIDE THE INFORMATION REQUESTED BELOW ON SEPARATE SHEETS OF PAPER ATTACHED TO THE APPLICATION FORM.**

- Describe the types of medical utilization review programs offered by the applicant, including but not limited to:
  - Second opinion program;
  - Hospital preadmission review;
  - Pre-inpatient service eligibility certification and
  - Concurrent hospital review to determine appropriate length of stay.
- Describe the process by which the applicant proposes to perform each of the utilization review services listed above. Specify
  - The steps followed by the applicant's personnel as they perform each type of review program; and
  - the categories of health care personnel that perform medical utilization review for the applicant, and whether those persons are licensed in this or any other state.
- On separate sheets of paper attached to the application form, describe the process that the applicant will use to address beneficiary and provider complaints, requests for redeterminations and appeals.
- The applicant is requested to enclose with the application copies of all materials used by the applicant to inform beneficiaries of the requirements of the utilization review plan and the rights and responsibilities of beneficiaries under the plan.
- Has the applicant's utilization review program been certified by the Utilization Review Accreditation Commission (URAC)?  
Please check one:  Yes  No  
Note: The applicant is requested to attach a copy of the accreditation certificate received from URAC.
- The applicant is requested to attach separate sheets of paper describing the procedures established by the applicant for preserving the confidentiality of medical information used in the utilization review process.
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List the telephone number(s), including toll-free numbers and fax numbers, at which beneficiaries and providers may reach representatives of the applicant. For each number listed indicate the number of lines maintained and the hours and days of the week during which the number is available.

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Indicate the hours or days of the week during which calls are unanswered or answered solely by the recordings or answering services that do not provide access to representatives during the call.

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I have read the foregoing application and attachments and state that the answers supplied therein are true and correct to the best of my knowledge and belief. The undersigned also acknowledges that all applicable state and federal laws to protect the confidentiality of medical information will be followed. Further, by submitting this application to the Insurance Department, the applicant acknowledges that it has read and will comply with the performance standards set forth in RSA 420-E and any applicable rules.

Ins 2001.06 Privileged Information. No information required to obtain a utilization review license shall be withheld by an applicant on the grounds that it is proprietary or otherwise confidential. Any information deemed confidential by the applicant may be submitted under separate cover, accompanied by a statement of the scope of the privilege claimed by the applicant and the basis for the claim of privilege. The applicant shall have the opportunity to request a hearing if the commissioner denies such a claim in whole or in part.

Signed on behalf of the applicant by: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Annual Renewal is Due by February 28th each year