HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT FORM

Oklahoma Insurance Department

Health Carrier External Review Annual Report Form

External Review Annual Summary for 20_____		Due by January 31 for the previous calendar year.	
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.			
1. Health carrier name:		Filing date:	
2. Health carrier address:			
City, State, Zip:			
3. Health carrier Website:			
4. Name of person completing this form:			
Email:	Phone:	Fax:	
5. Total number of external review requests received from the Oklahoma Insurance Department during the reporting period:			
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:			

Please submit to:
Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112-4511