APPLICATION FOR REGISTRATION AS AN INDEPENDENT REVIEW ORGANIZATION

Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105
405-521-2828

☐ Initial Application
☐ Renewal

Application for Registration as an Independent Review Organization

Type of Entity: ☐ Corporation ☐ Partnership ☐ LLC ☐ Other __________________

Contact Information for Application

Legal Name of Applicant	State of Domicile	Federal EIN	
Contact Person (Name and Title)	Phone ( )	Email	
Business Address (Do not use PO Box)	City	State	Zip
Mailing Address (if different from business address)	City	State	Zip

Contact Information for Initiating External Reviews (also to be made available to carriers and consumers)

Contact Person (Name and Title) or Department		Phone ( )	Email	
Mailing Address		City	State	Zip
Website	Toll-Free Telephone Number		Fax ( )	
Other Contact Information				

Applicant Attestation and Certification

Applicant certifies that it will notify the Oklahoma Insurance Department immediately if its accreditation is lost with the American Accreditation Healthcare Commission/URAC. Applicant acknowledges that the Oklahoma Insurance Department may terminate this license if the applicant loses accreditation or no longer satisfies the minimum requirements for licensure.

Applicant acknowledges that payment of any fees associated with any external reviews conducted pursuant to 36 O.S. § 6475.1 et seq. are the sole responsibility of the health carrier whose medical decision is being reviewed. Applicant understands that it has no recourse against the Oklahoma Insurance Department or the state of Oklahoma to the extent that any health carrier fails to pay any medical reviewer fees. Applicant authorizes the Oklahoma Insurance Department to verify information with any federal, state, or local government agency, insurance company or accrediting organization.

Applicant acknowledges and represents that it understands and will comply with Oklahoma's insurance laws and the rules of the Oklahoma Insurance Department. Applicant hereby represents that it will comply with all requirements imposed under 36 O.S. § 6475.1 et seq. and assures that no conflict of interest or improper controlling interest as outlined in the statute exists. Applicant further agrees to maintain and provide to the Oklahoma Insurance Department the information set out in 36 O.S. § 6475.15.

I certify that, under penalty of perjury, I am the person named herein and know the contents thereof, and that all of the information submitted in this application and its attachments is true and complete. I attest that I have the authority and capacity to execute this certification on behalf of the applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

______________________________	______________________________
Signature of person who completed application	Signature of Officer, Director, or Board Member
______________________________	______________________________
Printed Name	Printed Name
______________________________	______________________________
Title	Title
______________________________	______________________________
Date	Date

Please provide the following documents:

1. A copy of the most recent certificate from American Accreditation HealthCare Commission/URAC for Independent Review Organizations.
2. A schedule of fees.
3. A copy of the current Certificate of Authority provided by the Oklahoma Secretary of State.

Please submit this application and all required attachments to:

Oklahoma Insurance Department
External Review Program
400 NE 50th Street
Oklahoma City, OK 73105