HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT FORM

Oklahoma Insurance Department

Health Carrier External Review Annual Report Form

<table>
<tr><td colspan="3">External Review Annual Summary for 20_______</td><td colspan="3">Due by January 31 for the previous calendar year.</td></tr>
<tr><td colspan="6">Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.</td></tr>
<tr><td>1. Health carrier name:</td><td colspan="3"></td><td>Filing date:</td><td></td></tr>
<tr><td>2. Health carrier address:</td><td colspan="5"></td></tr>
<tr><td>City, State, Zip:</td><td colspan="5"></td></tr>
<tr><td>3. Health carrier Website:</td><td colspan="5"></td></tr>
<tr><td colspan="2">4. Name of person completing this form:</td><td colspan="4"></td></tr>
<tr><td colspan="2">Email:</td><td colspan="2">Phone:</td><td colspan="2">Fax:</td></tr>
<tr><td colspan="5">5. Total number of external review requests received from the Oklahoma Insurance Department during the reporting period:</td><td></td></tr>
<tr><td colspan="5">6. Total number of external review requests received from the Oklahoma Insurance Department during reporting period, include OID file numbers and patient names:</td><td></td></tr>
</table>

Please submit to:
Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105