

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF MANAGED CARE COMPLIANCE
201 MONROE STREET, Room 734
MONTGOMERY, AL 36104
(Mailing address: P.O. Box 303017, Montgomery, AL 36130-3017)
(334) 206-5178

APPLICATION FOR CERTIFICATION AS A UTILIZATION REVIEW AGENT

Date of Filing: _____

Part I. General Information

Name of Organization: _____

(D/B/A if applicable) _____

Federal ID Number: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Office Building: _____ Room Number: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Telephone Number: (____) _____ Fax Number: (____) _____

Normal Business Hours: _____

Type of Organization: _____ Individual _____ Partnership _____ Corporation

Contact Person & Title: _____

Contact Person(s) Phone Number _____ Fax Number _____

E Mail Address _____

Part II. Compliance with Standards

Is organization accredited by URAC (The American Accreditation Healthcare Commission)? _____ Yes _____ No

If yes, attach copy of current certificate of accreditation *specific to Health Utilization Management Standards*.

If no, attach a copy of your policies and procedures which support compliance with Code of Alabama §27-3A-5, a copy of the complaint and appeals procedures for utilization review determinations, Attachment A-additional UR sites, and Addendum.

Part III. Filing Fee

Submit the filing fee in the amount of one thousand dollars (\$1,000) made payable to the Alabama Department of Public Health. Organizations that are accredited by URAC (The American Accreditation Healthcare Commission) are exempt from this filing fee.

Part IV. Affirmation

I do solemnly swear or affirm that I am familiar with the laws of Alabama relating to utilization review agents; that I have complied with all of the requirements of Code of Alabama, _27-3A-5; that all of the foregoing information, the addendum, and documentary evidence submitted is true, complete, and correct to the best of my knowledge and belief.

Signature of Applicant

Name of Applicant (Print or type)

Title of Applicant

Sworn to and subscribed before me this _____ day of _____,
20____.

Notary Public

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF MANAGED CARE COMPLIANCE
201 Monroe Street, Suite 750
MONTGOMERY, AL 36104
(334) 206-5366

ADDENDUM TO APPLICATION FOR CERTIFICATION OR RENEWAL OF CERTIFICATION
AS A UTILIZATION REVIEW AGENT

Code of Alabama 30-3-194 requires state agencies to collect social security numbers for applicants for the issuance or renewal of licenses, certificates, or permits. This information will be held confidential and will not be provided as public record. Applicants and renewing utilization review agents not providing this information will be denied the privilege of conducting utilization review in Alabama.

Name of Organization

Name of Applicant (Type or print)
(Should be the senior official of the organization)

Signature of Applicant

Title of Applicant

Social Security Number of Applicant*

*(Federal ID numbers or company ID numbers are not acceptable)