

**RHODE ISLAND DEPARTMENT OF HEALTH**  
**Application for Certification/Re-certification to Perform**  
**Utilization Review\***

Name of utilization review applicant: \_\_\_\_\_

d/b/a in Rhode Island: \_\_\_\_\_

Application for new certification

Application for re-certification, if so:

Current certificate #: \_\_\_\_\_

Current expiration date: \_\_\_\_\_

Name of utilization review agency's President/CEO: \_\_\_\_\_

Compliance contact: \_\_\_\_\_ Title: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_

Billing contact: \_\_\_\_\_ Title: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_

**Application must be submitted in conformance with the *Utilization Review Application Guidelines*:**

- ◆ **I. UTILIZATION REVIEW APPLICATION INFORMATION: TAB A - F**
- ◆ **II. POLICIES AND PROCEDURES: TAB G - M**
- ◆ **III. ADVERSE DETERMINATION NOTIFICATIONS: TAB N**
- ◆ **IV. ENROLLEE INFORMATION: TAB O**
- ◆ **V. EXTERNAL REVIEW CONTRACTS: TAB P**

**Enclose the non-refundable application fee of \$500 made payable by check to the "General Treasurer, State of Rhode Island."**

**WAIVERS**

**Utilization Review Accreditation:**                     URAC                     NCQA

Provide evidence of current utilization review accreditation from the accrediting organization(s) and any correspondence that affects the review agency’s accreditation status. Refer to the Utilization Review Application Guidelines (TAB A, Waiver Requests, 1<sup>st</sup> bullet) for application requirements.

Is utilization review performed for mental health and substance abuse services?

**Yes** If yes, the review agency is not eligible for a URAC and/or NCQA waiver of the requirements of RIGL 23-17.12.

**No** If no, please indicate which review agency is performing utilization review for mental health and/or substance abuse services: \_\_\_\_\_

**Utilization review activities are conducted pursuant to contracts with the state or federal government or under other state or federal jurisdictions:**

Medicaid                     CHAMPUS                     ERISA

**Other:** \_\_\_\_\_

Provide evidence of any direct conflict with the requirements of RIGL 23-17.12 and R23-17.12-UR, along with the applicable policies and procedures, incorporated within the application.

**Ownership of review agency:**     Individual             Partnership             Corporation

**I hereby submit this application with the attached *Assurances* and supporting documents, as required under RIGL 23-17.12, which contain true and accurate information to the best of my knowledge and belief.**

**Signature of person authorized by the utilization review agency to submit this application:**

**Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*State of (.....)*  
*County of (.....)*  
*In....., in said county on this ..... day of .....A.D. 20....., personally appeared before me.....*  
*Of.....who, after signing the foregoing ownership report in my presence, made oath that the facts stated in said report are true.*

**NOTARY PUBLIC**

\*Please do not re-format the *Application for Certification/Re-certification to Perform Utilization Review* form.

**RHODE ISLAND DEPARTMENT OF HEALTH**  
**Application for Certification/Re-certification to Perform Utilization Review**  
**Assurances\***

Citations refer to the *Rules and Regulations for the Utilization Review of Health Care Services (R23-17.12-UR)*.

I am aware of Chapter 23-17.12 of the Rhode Island General Laws, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of utilization review agencies. If certification is granted, I, for, and on behalf of the utilization review applicant, hereby bind the review agency to the following:

1. That the review agency will comply with all statutory and regulatory requirements and adhere to any and all applicable state and federal laws; [2.9]
2. That the review agency or its reviewers shall not impede the provision of health care services; [3.2.12]
3. That no employee of, or other individual making an adverse determination for the review agency may receive any financial incentives based on the number of denials made; [3.2.13]
4. That the review agency has not entered into an agreement with its employees/agents that allows for compensation based on a reduction of services/length of stay/charges for the services/utilization of alternative treatment settings; [3.2.14]
5. That the decision to provide treatment or service to a patient is the responsibility of the attending provider and patient; [3.2.18]
6. That the determination of covered services and benefits is the responsibility of the payor; [3.2.19]
7. That the review agency shall monitor and evaluate the implementation of its operational policies and procedures on an annual basis; [3.2.5]
8. That all policies and procedures presented in this utilization review application comply with Chapter 23-17.12 of the Rhode Island General Laws and *R23-17.12-UR* and are approved by the governing body/CEO and incorporated into the review agency's operations throughout the certification period unless modified according to *R23-17.12-UR*, section 2.6; and [4.1 and 9.4]
9. Any proposed change to the application information, or that information on file at the Rhode Island Department of Health, will be provided for review prior to the implementation of such proposed change (such changes shall include the scope of services provided and changes in payors for which the review agency is performing utilization review in Rhode Island). [2.6]

**Signature of person authorized by the utilization review agency to provide the above assurances in connection with the utilization review agency's application:**

**Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*State of* (.....)

*County of* (.....)

*In*....., *in said county on this*.....*day of*.....*A.D.*

*20*....., *personally appeared before me*.....

*Of*..... *who, after signing the foregoing ownership report in my presence, made oath that the facts stated in said report are true.*

**NOTARY PUBLIC**

\*Please do not re-format the *Assurances* form.



**Rhode Island Department of Health**  
**3 Capitol Hill, Providence RI, 02908-5097**  
**MANDATORY ADDENDUM TO LICENSE APPLICATION**  
**Tax Payer Status Affidavit / Identity Verification**

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

**Licensee Declaration**

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the Tax Administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # \_\_\_\_\_)
- I am in state receivership. (Case # \_\_\_\_\_)
- I have been discharged from Bankruptcy.  
(Case # \_\_\_\_\_)

\_\_\_\_\_  
Type of Professional/Business License for which you are applying

\_\_\_\_\_  
Full Name (Please Print or Type)

\_\_\_\_\_  
Social Security Number (or FEIN for Business)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone Number (including area code if not 401)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Business (If Applicable)

*This form must be completed, signed and attached to your license application for processing.*