South Carolina
Department of Insurance

Capitol Center
1201 Main Street, Suite 1000
Columbia, South Carolina 29201

Mailing Address:
P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6095

HENRY McMASTER
Governor

RAYMOND G. FARMER
Director

Utilization Review Additional Questions

Company Name _____

1. Is there / Will there be a physical office in the State of South Carolina?
    a. If yes, please provide a Certificate of Authority from the SC Secretary of State.

    _____

2. Applicant's hours of operation within the State of South Carolina (Eastern Standard Time):

    _____

    a. Toll-free number(s) for accessibility:

    _____

    _____

    _____

    b. Number of incoming telephone lines:

    _____

    c. Show incoming call queue time:

    _____

3. If applicant has been reviewed by URAC, please attach a copy of the most recent report and certification.

    _____

4. Provide the total number of covered lives for which the reviewing personnel of your organization may be required to perform utilization review activities.

    _____

5. Provide a listing of all reviewing personnel, by specific qualification/specialty. Include a total of all physicians, by specialty, which support and/or supervise reviewing personnel.
    Please attach on separate pages.

Note: No other affidavits will be accepted. You must sign or electronically sign the initial/renewal application and forms provided by the SC DOI.

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6. Provide a copy of all materials designed to inform applicable patients of the requirements of the utilization plan, the rights of the patient under each contract, notification of adverse decision, appeal procedures, and confidentiality of patient's medical records (Federal and State). *Please attach on separate pages.*

I certify that I will comply with all applicable provisions of Title 38, Chapters 39 of the South Carolina Code of Laws. I certify all information submitted on this form and attachments is true and accurate. I understand that providing false information on this form may result in the revocation of the registration or imposition of administrative penalties for the Applicant under which this form is required.

Signature _____

Date _____

Name _____

Position _____

Subscribed and sworn to me before this _____ day of _____, 20_____.

Notary Signature _____

My Commission Expires _____

County of _____

State of _____

(Notary Seal Affixed Here)

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