THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT
21 South Fruit Street
Suite 14
Concord NH 03301
TELEPHONE 603-271-2261 FAX 603-271-1406

Roger A. Sevigny
Commissioner

GENERAL INSTRUCTIONS:

Send the completed application to:

New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301
Attn: Barbara Anderson
External Review Certification

- Respond to each question separately;
- Type responses;
- Mark each response with the number of the corresponding item number on the application;
- Submit bound application and use appropriately numbered tabs (3 ring binder is acceptable);
- Submit all requested information except where exceptions are identified;
- Submit 3 copies of the application package;
- Incomplete applications will not be processed;
- For renewal applications, submit application at least two months prior to expiration date of current certificate.

Note: False or misleading statements will result in denial or loss of certification and/or other action/penalty.

PLEASE NOTE: THE FOLLOWING ARE MINIMUM REQUIREMENTS FOR CERTIFICATION / RECERTIFICATION:

Under NH RSA 420-J: 5-d, II, (e), no entity shall be qualified for certification if it owns or controls, is owned or controlled by, or exercises common control over any of the following:

a. A health carrier;

b. A national, state, or local trade association of health carriers; or

c. A national, state, or local trade association of health care providers.

Under NH RSA-420-J: 5-d, II (e) (1) through (6), no independent review organization, nor any clinical peer reviewer assigned by the independent review organization to conduct the independent review, may have a material professional, familial or financial interest in any of the following:

a. The health carrier that is the subject of the independent review;

b. Any officer, director, or management employee of the health carrier that is the subject of the independent review;

c. The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the independent review;

d. The facility or institution at which the recommended healthcare service or treatment would be provided;

e. The developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose treatment is the subject of the independent review; or

f. The covered person or the covered person's authorized representative.

In addition, under NH RSA 420-J: 5-d, II, (h) (1) through (4), the following entities are not eligible for certification as an independent review organization:

a. Professional or trade associations of health care providers;

b. Subsidiaries or affiliates of such provider associations;

c. Health carrier or health plan associations; and

d. Subsidiaries or affiliates of health plan or health carrier associations.

I.

STATE OF NEW HAMPSHIRE INSURANCE DEPARTMENT INDEPENDENT REVIEW ORGANIZATION CERTIFICATION / RECERTIFICATION APPLICATION

Check One: New ☐ Renewal ☐

Name of Applicant

D/B/A

Mailing Address

City State Zip Code Telephone Number

Name of Chief Executive Officer

Mailing Address

City State Zip Code Telephone Number (Direct Line)

Tax Status: Privately Held Corporation ☐ Not for Profit Corporation ☐

Publicly Traded Corporation ☐ Partnership ☐ Other (Specify) ☐_____

Federal Tax ID# _____

State of Incorporation_____

List all states in which applicant is incorporated, licensed, certified or otherwise authorized to conduct business: (Attach separate sheet if necessary)

_____

_____

_____

II. ORGANIZATION OF APPLICANT:

A. Provide a description of the organizational structure of the applicant.

B. Attach an organizational chart.

C. Attach copies of certificates of incorporation, articles of organization and by-laws or operating agreement for the applicant.

D. Attach organizational chart showing all lines of authority within a holding company or parent/subsidiary system, if applicable.

E. List and describe the scope and relationship of all agreements between the applicant and health care services entities, health care providers and management service organizations.

III. MANAGEMENT OF APPLICANT:

A. Provide a list of all management employees with independent review responsibilities, including a job description that sets forth the independent review responsibilities of each position.

B. Attach a completed and notarized Conflict of Interest Attestation Form (Attachment A- Form CIAF), executed by the Chief Executive Officer of the applicant on behalf of all directors, officers, executives and the Medical Director.

C. Provide the names of all entities and organizations owned or controlled by the applicant and / or the applicant's owners.

D. Provide completed Personal Background Information Forms (Attachment B -Form PBIF) for all owners (including beneficial owners) directors, partners, officers, Medical Director and senior management (Sr. VP and higher) employees of the applicant.

E. Provide a description of the Medical Director's responsibilities for selecting and matching peer reviewers, and for quality control programs.

F. Medical Director must complete and submit Medical Director Disclosure Form (Attachment C - form MDD).

G. Attach completed and notarized Authorization/Release Form executed by each senior officer (senior vice present and higher), director, partner, trustee, member, Medical Director, and owner of 10% or more of the applicant. (Attachment D – Form ARF).

IV. CONTRACTED SERVICE PROVIDERS/CLINICAL PEER REVIEWERS:

A. Attach a list of all reviewers in the proposed clinical peer review network. Include the name of each reviewer, a copy of the state license, that includes license number(s) and expiration date, clinical discipline(s) and all board certifications where applicable.

B. Provide a copy of the procedure that ensures the adequacy and maintenance of the peer review network.

C. Provide a copy of the procedures employed by the medical director which ensures that all clinical peer reviewers conducting independent review are appropriately matched by specialty to conduct clinical peer reviews. At a minimum, procedures should address:

1. Appropriate medical training.
2. Board Certification in appropriate specialties.
3. Training by the applicant to conduct reviews in accordance with all of the applicant's policies and procedures.
4. Are not or have not been the subject of disciplinary action and or malpractice litigation naming the peer reviewer.
5. Criteria used for selecting clinical peer reviewers for reviewer "pool".
6. Criteria used for matching clinical peer reviewers to specific cases.
7. The name, title and credentials of the person (s) making and/or reviewing numbers 5 and 6 noted above.

D. Provide a copy of the procedures used to ensure that clinical peer reviewers assigned to review a particular appeal, do not have a prohibited conflict of interest pursuant to RSA 420-J: 5-d, II (e); and

E. Attach a copy of standard peer reviewer contract form/template used by the applicant to engage peer reviewers.

F. Attach completed provider network conflict of interest attestation form (Attachment E – Form PNCIAF).

V. QUALITY ASSURANCE AND CONFIDENTIALITY:

A. Provide a copy of the quality assurance program established by the applicant and the most recent internal quality assurance oversight report. Provide the name, credentials and phone number of the person (s) responsible for internal review of quality assurance programs.

B. Provide a copy of the policies and procedures employed to protect the confidentiality of medical and treatment records, and review materials, in accordance with applicable State and Federal laws.

C. Is the applicant certified by NCQA (National Committee for Quality Assurance)?
Yes _____ No_____

Is the applicant certified by URAC?

Yes_____ No_____

If certified by either or both of the above, provide a copy of your most recent certification.

VI. APPEAL PROCESS AND INFORMATION SYSTEMS:

A. Provide copies of standard and expedited appeals policies and procedures that comply with NH RSA 420-J: 5-b and c, and Ins. Rule 2703.

B. Provide an illustrative flow chart of the sequence through which an independent review will be processed, from receipt through the notification to the patient, health plan and the NH Insurance Department. Such description shall take into account the requirements of NH RSA 420-J: 5-b, IX and X.

VII. FINANCIAL CONDITION:

A. Provide the applicant's most recent year-end audited financial statement, or if publicly traded, most recent U.S. Securities and Exchange Commission Form 10K and 10Q filings.

VIII. FEES:

A. Attach a schedule of fees that will be charged for independent reviews. The fee schedule should include fees for both standard and expedited reviews, and if applicable, price differentials for single reviewer case reviews and multiple reviewer case reviews.

IX. HOLDING COMPANY REGULATORY ACTIONS:

If the applicant is a wholly owned subsidiary of another legal entity, has the applicant's holding company, ever been subjected to financial penalties or suspension or revocation of its operating certificate or license or contract because of failure to comply with provisions governing its conduct and operation?

YES ☐ NO ☐

NOTE: If "YES," complete for each violation.

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

PENALTY IMPOSED

NAME AND ADDRESS OF OPERATION INVOLVED

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING IT

PENALTY IMPOSED

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Roger A. Sevigny
Commissioner

AFFIRMATION

I subscribe and affirm, under penalty of perjury, that the statements made in this application, including statements made in accompanying papers, have been examined by me and to the best of my knowledge and belief are true, correct and complete, and that I am duly authorized to execute this affirmation.

I hereby affirm on behalf of the applicant that the applicant provide ready access to the Insurance Commissioner to all data, records, and information collected and maintained concerning the organization's independent review activities inclusive of any reports the Commissioner determines necessary to evaluate the independent review process.

Date: _____ For_____
(Print or type Applicant's name)

By_____
(Print or type name of the authorized signatory)

Signature_____

Title_____

CORPORATE ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared _____
(Name of corporate officer signing this document)
the _____ of the above-named corporation, and acknowledged that he
(Title of officer)
or she, as an officer being authorized so to do, executed the foregoing instrument for the purposes therein contained, by signing the name of the corporation by himself or herself as an officer. IN WITNESS WHEREOF I have hereunto set my hand and official seal.

(SEAL) _____
Notary Public/JP

My Commission Expires_____
(Date)

INDIVIDUAL OR PARTNERSHIP ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared_____ proven to me to be the same person whose name is signed to the foregoing instrument, (Name of person signing this document) and acknowledged the execution thereof for the uses and purposes set forth therein. In WITNESS WHEREOF I have hereunto set my hand and official seal.

(SEAL) _____
Notary Public/JP

My Commission Expires_____
(Date)

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Commissioner

PERSONAL BACKGROUND and FINANCIAL DISCLOSURE STATEMENT EXTERNAL REVIEW ORGANIZATION APPLICANT

INSTRUCTIONS:

- To be completed by each principal/owner/investor of 10% or more of the applicant, and each officer of the applicant, each manager (senior, vice president or higher), member, partner, director, Medical Director and trustee.
- Publicly traded companies and wholly owned subsidiaries of publicly traded companies may submit the company's or the parent company's most recent SEC 10K & 10Q in lieu of this form.
- Please type or print. Complete all items. Attach additional sheets as necessary or indicated. This form may be duplicated if additional copies are required.

Date_____

NAME OF APPLICANT: _____

TAX ID#: _____

1. IDENTIFYING INFORMATION:

Name of (Owner, Officer, Director, Manager, Trustee, Partner, Other – circle those that apply)

_____

Home street address: (do not use P.O. box address, do not use business address)

Street_____ Apt. _____

City_____ State_____ Zip Code_____

_____

Mailing Address (if different)

Other names by which you have been known:

_____

Date of Birth_____ Tax ID Number: _____

Place of Birth_____

(City) (State)

Driver's License #_____State_____

2. EMPLOYMENT: Attach a separate sheet listing your work history, beginning with your current employment, and all business with which you have been involved, and/or all periods of unemployment for the last 10 years. Include all corporations, partnerships or any other business ventures in which you had an investment or interest of 10% or more, or with which you have been associated as an officer, director, or in a capacity influencing policy or management. Also include dates of association, job title, name and address of the business/employer, description of your duties/responsibilities, name of immediate supervisor and reasons for leaving.

3. LICENSING HISTORY: Have you ever had a license to engaged in a regulated business or profession revoked, suspended or denied, or been subject to any other disciplinary proceedings by this or any other state licensing authority? _____ If yes, attach a separate sheet, which indicates the dates, licensing authority, and reason(s) for revocation, suspension, denial or disciplinary proceeding.

4. GENERAL CHARACTER: Have you ever been convicted of any misdemeanor or felony or other offense involving breach of trust, theft, forgery, deception, false advertising, false statements, fraudulent or dishonest dealing, or similar offense, or had a final judgment entered against you in a civil action upon grounds of fraud, misrepresentation, deceit or similar reason? _____ If yes, list on a separate sheet the type of offense or judgment, the name and address of the court before which the case was heard, docket #, the date of the conviction or judgment and the sentence, penalty or award ordered.

5. AFFILIATION WITH OTHER HEALTH CARE OPERATIONS: INSTRUCTIONS: The purpose of this section is to obtain a complete listing of any health care operations with which the owners, officers, directors, executives or medical director of the proposed Applicant have been affiliated within the past 10 years. Affiliation with health care operations for the purposes of this section includes serving as an officer, director, and member of the management staff, stockholder of 10 percent or more of stocks or key advisor for the health care operation.

A. For the past 10 years, have you owned or operated any health care or health related operations or held a management position or had any affiliations with health care or health related operations in New Hampshire, or in any other state?

YES ☐ NO ☐

NOTE: If "YES," complete the following chart:

Name and Address of Health Care Corporation	Affiliation Dates From/To	Nature of Affiliation	Licensing Agency

(Cont'd) AFFILIATION WITH OTHER HEALTH CARE OPERATIONS

B. Are/were these health care operations cited for non-compliance with applicable laws and regulations during your affiliation?

YES ☐ NO ☐

NOTE: If "YES," complete the following: (attach additional pages if necessary)

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING VIOLATION (name & address)

PENALTY IMPOSED

6. OTHER INFORMATION: Provide any other information concerning your personal history you consider relevant to you.

7. COMPLETE ATTACHED AUTHORIZATION/ RELEASE FORM (Attachment D).

AFFIRMATION:

I hereby subscribe and affirm that the foregoing statements, including statements made in any accompanying papers, have been examined by me and to the best of my knowledge and belief are true, accurate and complete.

_____
Name (Type or Print)

_____ _____
Signature Date

_____
Title

ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared_____ known to
(Name of person signing this document)
me personally or proven to me to be the same person whose name is signed to the foregoing instrument, and acknowledged the execution thereof for the uses and purposes therein set forth. In WITNESS WHEREOF I have hereunto set my hand and official seal.

_____
Notary Public/JP

My Commission Expires_____
(Date)

(SEAL)

(Attachment B – Form PBIF)

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Roger A. Sevigny
Commissioner

Conflict of Interest Attestation Form

I, _____ in my capacity as Chief Executive Officer of the applicant do hereby
(Name of Chief Executive Officer)

attest and affirm under penalty of perjury that _____ has no disqualifying relationship as described (Applicant)

in NH RSA 420-J: 5-d, and further, that neither _____nor any of its owners, partners, officers, (Applicant)

directors, medical director, management employees, or clinical peer reviewers currently employed or engaged have any material affiliation as prohibited by NH RSA 420-J: 5-d.

Name_____
(Type or Print name)

Title_____

Signature_____Date_____

ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared_____ known to
(Name of person signing this document)
me personally or proven to me to be the same person whose name is signed to the foregoing instrument, and acknowledged the execution thereof for the uses and purposes therein set forth. In WITNESS WHEREOF I have hereunto set my hand and official seal.

_____
Notary Public/JP

My Commission Expires_____
(Date)

(SEAL
(Attachment A – Form CIAF)

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MEDICAL DIRECTOR DISCLOSURE FORM
To be completed by Medical Director Only

Name of Medical Director: _____

Name of IRO Applicant**:** _____

LICENSES:

Type of Medical License (Including specialty)	State Granting License and Address	Date Issued	Expiration Date

MEDICAL EDUCATIONAL HISTORY:

Institution	Address	Attended from/to	Degree	Date Received

HISTORY OF ANY LEGAL ACTIONS:

1. Have you ever changed your name or used an alias?

   YES ☐ NO ☐

   NOTE: If "YES," attach an explanation including other names(s) date(s) and the reason(s) for each change. Include copies of any relevant court orders approving such name change (s).

2. Except for minor traffic violations, have you ever been indicted, convicted, had a sentence suspended, or been pardoned of a conviction for any crime?

   YES ☐ NO ☐

3. Are there any criminal actions pending against you?

   YES ☐ NO ☐

4. Have you ever been named as a defendant in any civil action or proceeding alleging medical malpractice or similar cause of action?

   YES ☐ NO ☐

NOTE: If "YES" to 2, 3, or 4, attach explanation(s) including the date of the action or proceeding, place (name of court and city where filed), the civil docket number, if available, and the disposition of the case, if any.

5. Have you ever been an owner, officer, trustee, management employee or controlling stockholder of an entity which, while you occupied any such position or served in any such capacity with respect to it:

   a. suffered the suspension or revocation of its certificate of authority or license to do business in any state?

   YES ☐ NO ☐

   b. was denied a certificate of authority, license or contract to do business in any state?

   YES ☐ NO ☐

NOTE: If "YES" to any of the above, attach full explanation and copies of relevant legal documents.

AFFIRMATION:

I hereby subscribe and affirm that the foregoing statements, including statements made in any accompanying papers, have been examined by me and to the best of my knowledge and belief are true, accurate and complete.

_____
Name (Type or Print)

_____ _____
Signature Date

_____
Title

ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared_____ known to
(Name of person signing this document)
me personally or proven to me to be the same person whose name is signed to the foregoing instrument, and acknowledged the execution thereof for the uses and purposes therein set forth. In WITNESS WHEREOF I have hereunto set my hand and official seal.

_____
Notary Public/JP

My Commission Expires_____
(Date)

(SEAL)

(Attachment C –Form MDD)

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Commissioner

PROVIDER NETWORK CONFLICT OF INTEREST ATTESTATION FORM

The President/CEO of the applicant must complete and execute this document on behalf of all listed peer reviewers. Identify potential conflicts of interest for each reviewer.

Name	State and License No. (s)	Clinical Specialty	Practice Affiliations

AFFIRMATION:

I hereby subscribe and affirm that the foregoing statements, including statements made in any accompanying papers, have been examined by me and to the best of my knowledge and belief are true, accurate and complete.

_____ _____
Name (Type or Print) Signature

_____ _____
Title Date

ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared_____ known to
(Name of person signing this document)
me personally or proven to me to be the same person whose name is signed to the foregoing instrument, and acknowledged the execution thereof for the uses and purposes therein set forth. In WITNESS WHEREOF I have hereunto set my hand and official seal.

_____
Notary Public/JP

My Commission Expires_____
(Date)

(SEAL) (Attachment E – Form PNCIAF)

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Commissioner

AUTHORIZATION/RELEASE FORM

INSTRUCTIONS: To be completed by each senior officer (senior vice president and higher), director, partner, trustee, member, Medical Director, and owner of 10% or more of the applicant. PLEASE TYPE. This form may be duplicated. Publicly traded corporations, and the wholly owned subsidiaries of publicly traded corporations, may submit the company's or the parent corporation's most recent U.S. Securities and Exchange Commission Form 10-K and 10-Q in lieu of this authorization.

Submitted in connection with an application for an Independent Review Organization pursuant to RSA 420-J:5-d by:

_____
(Name of Applicant)

(Name of Officer, Owner, Director, Manager, Partner, Trustee, Member, Medial Director)

I hereby authorize the State of New Hampshire Insurance Department to request and receive reports of police and criminal records from any and all law enforcement officials, and further authorize that such information may be released to the State of New Hampshire Insurance Department by such officials upon presentation of this authorization, or a photostatic copy hereof. I understand that the State of New Hampshire Insurance Department will utilize any information it receives as a result of this authorization solely for purposes of determining compliance with certification standards set forth in RSA 420-J:5-d, as applicable. I understand that this authorization does not expire.

_____ (Type Name)

_____ (Date of Birth)

_____ (Signature) (Date)

_____ (Number and Street Address)

_____ (Title)

_____ (City and State of Residence)

_____ (Tax ID#)

_____ (Zip Code)

INDIVIDUAL ACKNOWLEDGEMENT

State of_____}

County of_____} ss.

On this _____day of _____, 20____ before me _____,
(Name of Notary/JP)
the undersigned officer, personally appeared_____ known to
(Name of person signing this document)
me personally or proven to me to be the same person whose name is signed to the foregoing instrument, and acknowledged the execution thereof for the uses and purposes set forth therein. In WITNESS WHEREOF I have hereunto set my hand and official seal.

_____
Notary Public/JP

My Commission Expires_____
(Date)

(SEAL)
(Attachment D - Form ARF)