Arkansas Department of Health

Utilization Review Certification Program
Health Facility Services
Application for Certification as a Private Review Agent
(Please Type)

Name/dba:_____

Ownership: _____

Corporate Address: _____

City/State/Zip: _____

Phone/Fax:_____

Medical Director:_____

Authorized Representative/Title: _____

Contact Person/Title:_____

Mailing Address:_____

City/State/Zip: _____

Phone/Extension:_____ Fax:_____

E-mail:_____

Medical areas in which services are provided (check all that apply):

_____Medical/Surgical _____Workers Compensation _____Other (specify)
_____Behavioral Health _____Bill Review _____
_____Chiropractic _____Single Specialty of _____

Lines of business/services available:_____

_____

Number of covered lives: Arkansas:_____ Outside Arkansas:_____

National Accreditation(s):_____

For Program use only:

Date Received:_____Date Certified:_____Expiration Date:_____

Certification Number:_____Customer Number:_____Fee: $2,500.00

Notes:_____

Arkansas Department of Health

Utilization Review Certification Program
Health Facility Services
Application Affidavit & Agreement

(Please Type)

Organization Name:_____

dba:_____

Authorized Representative:_____

I hereby certify that I have read the aforementioned Application and that all statements are true to the best of my knowledge and belief. I certify that I will comply with all specific assurances contained in Section 4 of the Rules & Regulations for Utilization Review in Arkansas. I am aware that any willful misrepresentation of any material fact contained in this Application will subject me to denial or revocation of this Certification (See Section 7 of the Rules & Regulations for Utilization Review in Arkansas) and will subject me to penalties as set forth in Arkansas Act 537 of 1989, (A.C.A. 20-9-901 - 20-9-914).

_____

Authorized Representative Signature

Subscribed and sworn to before me on this the

_____day of _____month, _____year

_____Notary Public

Name Signature

My commission expires on:_____