WASHINGTON STATE OFFICE OF THE INSURANCE COMMISSIONER INDEPENDENT REVIEW ORGANIZATION (IRO) APPLICATION FOR CERTIFICATION

IRO BUSINESS NAME

Legal Name	
DBA Name(s) if applicable	
Name of Chief Executive Officer	

BUSINESS AND MAILING INFORMATION

Domicile Address City, State ZIP Code		Mailing Address City, State ZIP Code	
Phone		Fax	
General Email		Website Address	
FEIN		Tax Status	☐ Privately Held ☐ Not-for-Profit
Has applicant or any of its holding companies operated as an IRO (or external review organization) for any other state? ☐ Yes ☐ No			
If yes, please attach a list of states, and whether a credential is required to work as an IRO. Please include copies of all credentials you hold from other states.			
Has applicant been cited for any violation, deficiency, or improper conduct in any state? ☐ Yes ☐ No			
If Yes, provide an explanation and attach any additional documentation.			

IRO INDIVIDUAL CONTACT INFORMATION

Primary Contact for Certification Purposes			
Contact Name		Title	
Address City, State ZIP Code		Phone/Fax	
		Email	
Primary Contact for Independent Review Referrals from Insurance Carriers			
Contact Name		Title	
Address City, State ZIP Code		Phone/Fax	
		Email	
Primary Contact for Independent Review Decision Reporting (If different than contact above)			
Contact Name		Title	
Address City, State ZIP Code		Phone/Fax	
		Email	
Medical Director			
Contact Name		Phone	
Address City, State ZIP Code		Email	
		Fax	
State of Licensure		Credentials	☐MD ☐ DO

Control of IRO

Provide the following:

1. Certificates of incorporation, articles of organization and by-laws or operating agreement for the IRO, holding company or parent entity;
2. A current Certificate of Good Standing from the Washington Secretary of State as a foreign registered entity.
3. A current Certificate of Good Standing from the domiciliary Secretary of State.
4. Organizational chart. It must show all affiliations of the applicant and all lines of authority within a holding company or parent subsidiary system (if applicable).
5. Name of each stockholder or owner of more than 5% of any stock or options.
6. Name of any holder of bonds or notes that exceed one hundred thousand dollars.
7. Name and type of business of all corporations and organizations the applicant controls or is affiliated with, and the nature and extent of any such affiliation or control.
8. A list of names, addresses, and official positions, of each director, officer, executive, and any other corporation or organization that applicant controls or is affiliated with. Include a description of any relationship these individuals have with entities listed in RCW 48.43.537(3)(d). For each individual listed, attach a completed Biographical Affidavit. Use the prescribed Form 11 available through the NAIC Website.
9. An estimate of the percentage of applicant's revenues anticipated to be derived from reviews conducted under RCW 48.43.535;
10. A list of any potential conflicts of interest as described in WAC 284-43A-010(9), WAC 284-43A-050.

Qualifications and Experience

1. Describe applicant's experience and expertise reviewing health care in terms of medical necessity, appropriateness and the application of other health plan coverage provisions. WAC 284-43A-020(3).
2. Provide a description of applicant's procedures to ensure that clinical reviewers and contract specialists assigned to a particular review do not have a prohibited conflict of interest consistent with WAC 284-43A-010(9), WAC 284-43A-050 and corresponding regulations.
3. Provide a description of the areas of expertise of the health care professionals and contract specialists making review determinations and the procedures to be used in making review determinations. RCW 48.43A.537(3)(f)(g).
4. Describe the role of the Medical Director, including a description of the Medical Director's expertise to function as such. WAC 284-43A-040(9).

False or misleading statements may result in denial of application, loss of certification and/or other action or penalty.

No entity shall be qualified to submit an application if it is a subsidiary of, or is any way owned or controlled by a carrier or an association of health care providers or carriers.

Applicant's Attestation

"I declare under penalty of perjury under the laws of the State of Washington that I have read and will abide by Chapters 48.43.535 RCW, 48.43.537 RCW and 284.43A WAC and the contents of this application and contents of all attachments are true and correct."

Signature of Company Officer

Printed Full Legal Name

Title

Signature of Company Officer

Printed Full Legal Name

Title

State of)
County of)

Sworn before me this day of , 20 .

Notary Public - My Commission Expires: