

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."

