MISSISSIPPI DEPARTMENT OF HEALTH

Application for Certification
Private Review Agency

I. **Agency** ______________________________

Address ______________________________
Number and Street City State Zip Code

Telephone Number (   ) ________________

Fax Number (   ) ________________

Director ______________________________
Name Title

Person to be contacted for additional information:

______________________________ (   ) ________
Name Title Telephone Number

II. **Specify if Agency is operated by an individual, partnership, corporation, or other.** ______________________________

A. If operated by an individual, provide name and address:

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B. If operated by a partnership, provide full name and address of each partner:

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C. If operated by a corporation:

1. Provide full name and address of corporation:

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2. Provide full name, title, and address of each officer:

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3. List each individual who owns five (5) percent or more of the stock, including their current mailing and/or street address and percentage of ownership. If five (5) percent or more of such stock is owned by another corporation, furnish the same information requested above.

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III. How will this agency address the requirement that no adverse determinations shall be made without prior evaluation and concurrence in the adverse determination by a physician licensed to practice in Mississippi?

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IV. Agency Employees.

	Full Time	Part Time	Under Arrangement
Administrative			
Physicians			
Registered Nurses			
Clerical			

Other (Specify)

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If a physician review organization is utilized by this agency, provide name and address:

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V. Documents to be submitted with this certification application:

A. Utilization Review Plan that includes a description of review criteria, standards and procedures to be used in pre-admission certification of proposed hospital and medical care, concurrent and retrospective review of delivered hospital and medical care, and the provisions by which patients, physicians or hospitals may seek reconsideration or appeal of adverse decisions by the private review agents.

B. Type and qualifications of all personnel who perform utilization review.

C. Policies and procedures to insure that a representative of the private review agent is reasonably accessible to patients and providers in this state.

D. Policies and procedures to insure confidentiality of individual patient’s medical records.

E. **Copies of materials used to inform patients and providers of the requirements of the Utilization Review Plan.**

F. **List of the names and addresses of all third party payers for which the private review agency performs utilization review in Mississippi.**

I (we) do hereby certify on behalf of ________________________________ after diligent research, inquiry and study, that the information and material contained in this foreqoing application for a certificate is true, accurate and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi State Department of Health will rely on this information and material in making its decision as to the issuance of a certificate, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth and accuracy, the State Department of Health may reject the application. It is further understood that if a certificate is issued based upon the evidence contained in the application, such certificate may be canceled or revoked, if the State Department of Health determines its findings were based on evidence not true, factual, accurate and correct.

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Signature **Signature**

____

Title **Title**

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Date

Make checks payable to: **Mississippi Department of Health**

Mail to: **Mississippi Department of Health**
Health Facilities Licensure and Certification
P. O, Box 1700
Jackson, MS 39215-1700___________

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