Mississippi State Department of Health

Application for Recertification
Private Review Agency

I. **Agency** _____

Address _____
Number and Street City State Zip Code

Mailing Address _____
City State Zip Code

Telephone Number ( ) _____

Fax Number ( ) _____

Director _____ ( ) _____
Name Title Telephone Number

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:

_____

_____

_____

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

_____

_____

_____

C. If operated by a corporation:

1. Provide full name and address of corporation:

_____

_____

_____

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

_____

_____

_____

D. If the facility is owned by a corporation, 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.

_____

_____

_____

_____

III. Agency Employees:

	Full-time	Part-time	Under Arrangement
Administrative	_____	_____	_____
Physicians	_____	_____	_____
Registered Nurses	_____	_____	_____
Clerical	_____	_____	_____
Other (Specify)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

_____

_____

_____

IV. How does 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?

_____

_____

_____

_____

_____

V. **Based on the agency's activities in Mississippi during the past two years of certification, please provide the following statistics:**

Total Number of Precertification/Preadmission Reviews _____

Total Number of Denials _____

Total Number of Appeals _____

Total Number of Denial Decisions Reversed _____

Total Number of Concurrent Reviews _____

Total Number of Denials _____

Total Number of Appeals _____

Total Number of Denial Decisions Reversed _____

Total Number of Retrospective Reviews _____

Total Number of Denials _____

Total Number of Appeals _____

Total Number of Denial Decisions Reversed _____

VI. **If there have been any changes in the following documents, please submit with this recertification application, and designate the changes.**

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 agent.**

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 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 foregoing 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 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 Department Of Health determines its findings were based on evidence not true, factual, accurate and correct.

_____ _____

Signature Signature

_____ _____

Title Title

_____

Date

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

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