



Illinois Department of Insurance

JB PRITZKER
Governor

Robert H. Muriel
Acting Director

Re: Utilization Review Organization Renewal Application

Dear Sir/Madam:

If you wish to renew your Utilization Review Organization registration, all information requested on the attached renewal application must be furnished and accompanied by a check for the appropriate renewal fee. All checks are to be made out to the Director of Insurance. Should your company no longer engage in utilization review, please notify this Department in writing. Any entity which operates a program for utilization review in this State and fails to register such program may be construed as an unauthorized insurer and will be subject to corrective action.

Pursuant to applicable law, those organizations performing utilization review are required to pay a biennial fee of \$3000.00, except that any organization accredited by one of the following is only required to pay a biennial fee of \$1500.00.

1. For Health Care Utilization Review Organizations, accredited with the American Accreditation Healthcare Commission (URAC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA) or the Accreditation Association for Ambulatory Health Care (AAAHC); or
2. For Workers' Compensation Utilization Review Organizations, accredited with the American Accreditation Healthcare Commission's (URAC) Health Utilization or Workers' Compensation Utilization Management standards

Registration standards, guidelines, exhibits and URAC links can be accessed at:
<http://insurance.illinois.gov/URO/URACHealthUMv60.pdf>

If you have questions, please contact the Illinois Department of Insurance at 217-557-6953 or
DOI.Managed.Care@illinois.gov

Sincerely,

A handwritten signature in blue ink, appearing to read "Jennifer Reif".

Jennifer Reif
Deputy Director
Health Products



Illinois Department of Insurance

Health Care/Workers' Compensation Utilization Review Renewal Registration Form

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001
877-850-4740 (toll free)
217-524-4872 (TDD)
<http://insurance.illinois.gov>

Updated - 05/30/2019

****This form must be completed in its entirety. If any fields are not completed upon submission, it will be rejected****

<u>Company Information</u>			
Name		FEIN	
Address	City	State	Zip
Contact Person		Email	
<u>Renewal registration for Health Care and Workers' Compensation Utilization Review Programs covering period</u>			
From		To	
<u>Additional Information</u>			
Number of lives for which utilization review is conducted by each utilization program for the current year:	Health Care	Workers' Compensation	
Number of lives for which utilization review is conducted by each utilization program for the previous year:	Health Care	Workers' Compensation	
<u>Additional Documentation Required</u>			
Health Care - Please provide a current copy of the applicable accreditation certificate from URAC, JCAHO, NCQA or AAAHC; and			
Workers' Compensation - Please provide a current copy of the applicable accreditation certificate from URAC; and			
Any material changes to the information filed under your prior registration; and			
A check for registration: \$1,500 if accredited by URAC, JCAHO, NCQA or AAAHC (Health Care Only) or \$3,000.00 if unaccredited.			
<u>Affirmation (to be signed by an officer or director of the utilization review organization):</u>			
I, _____ do hereby certify that (typed or printed name and title)			
_____ (utilization review organization)			
complies with Health and/or Workers' Compensation Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health and/or Workers' Compensation Utilization Management Standards, and do hereby affirm that all of the information presented in this application is true and correct.			
Signature _____		Date _____	